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Original Articles.

CROUPOUS PNEUMONIA.

BY R. M. CUNNINGHAM, M. D., BIRMINGHAM, ALA.

There is, perhaps, no disease of more practical importance to the physician than croupous pneumonia.

According to Juergensen, about "66 per cent. of the total mortality is due to this disease, and about 12.7 per cent. of the mortality from internal diseases."

"Pneumonia occurs in all degrees of latitude, and does not appear to be more frequent in one latitude or climate than in another." (Ziemsen's Cyclopedia, vol. v., p. 12.

These two facts alone make the disease one of vast importance to every physician.

Notwithstanding these facts, there seems, even at this time, some confusion in the nomenclature of the various forms of pneumonia, their essential anatomical, pathological and etiological differences. The two forms of pneumonia most generally encountered in practice are the croupous and catarrhal. The same tissue is involved in both, to-wit: The intercellular air passages of Rainey, or the air sacs of Waters, and the cells or alveoli that open into them—collectively called the vesicular structure of the pulmonary parenchyma. That we may be more clearly understood, I beg your pardon for refreshing your minds for the moment on anatomy.

The bronchial tubes, after being reduced by dichotomous division—as a rule—to the diameter of 1-50 to 1-30 of an inch, generally from 4 to 9 to the lobule, change their structure and continue as "irregular passages through the substance of the lobule, their sides and extremities being closely covered by numerous sacular dilatations, the air cells." They are from "1-200 to 1-70 inch in diameter, *being largest* on the *surface* at the free borders, and at the apex; and smallest in the interior." Their walls are formed by the interlacing of the longitudinal elastic bundles and fibrous tissue; the muscular fibres disappear, and the mucous membrane becomes thin and delicate and lined with a layer of squamous epithelium. The latter membrane lines the air cells, and forms, by its reduplications, the septa intervening between them."

The ramifications of the pulmonary artery and the beginning of the pulmonary veins, all forming fine and delicate plexus between these structures, form with the air sacs and cells, the essential parenchymatous structure of the lobules, and these, in turn, form the lobes, and the lobes the lungs.

The essential anatomical lesions of both these forms of pneumonia are found in these structures, but differing widely in their distribution, extent, causation and pathology.

I submit, in this connection, the opinions of two of America's most distinguished authors. Loomis says: "Croupous pneumonia is an acute general disease with a characteristic local pulmonary lesion. Anatomically considered, it is an acute inflammation of the vesicular structure of the lungs, resulting in infiltration of the alveoli with inflammatory products, which renders them impervious to air. This condition is known as hepatization."

Pepper says: "Catarrhal pneumonia is an inflammation of the parenchyma of the lungs, frequently bilateral and affecting scattered groups of lobules, which may, however, coalesce, so that considerable areas of lung-tissue become continuously involved. This anatomical distribution explains the name lobular as opposed to that of the lobar or croupous form."

Thus, according to these authors, the essential lesions of both forms of pneumonia consist in inflammation of the "vesicular structure," or "parenchyma" of the lungs. But this

inflammation, in its causation, distribution and extent, nature, course, products and results, differs so widely in the two forms that in reality they have almost nothing in common except the character of tissue involved.

I submit, in parallel columns, some of the most important features of the two forms:

CROUPOUS PNEUMONIA.	CATARRHAL PNEUMONIA.
1. An acute general constitutional disease, caused by a specific materies morbi, possibly the pneumococcus of Freedlander or Franklin coccus; at any rate, a germ of some description, probably not as yet fully demonstrated; generally primary, and when occurring as an intercurrent affection, is coincidental or possibly determined by the physical condition of the patient, acting either as a predisposing or exciting, but not as the *essential cause*, and having a characteristic local pulmonary lesion, to-wit: "inflammation of the vesicular structure" as its "anatomical sign."	1. An acute, subacute or chronic local disease, not generally constitutional nor infectious, consisting of a catarrhal inflammation of the vesicular structure, or pulmonary parenchyma, always secondary, being due, as a rule, to bronchial catarrh, is often a complication, therefore having for its essential cause some disease having for one of its anatomical signs catarrh of the bronchi, or the result of primary bronchitis, or may result, simultaneously, with bronchial catarrh, having a common cause.
2. Self-limited, running, as a rule, a typical course, usually terminating by crisis, in cases that recover, with complete restoration of the inflamed structures to their normal condition.	2. Is not self-limited, runs an atypical course, seldom or never ends by crisis, and, as a rule, more or less permanently, in recovery, leaves behind it permanent lesions.
3. The inflammation, as a rule, simultaneously involves the lobules of a whole lobe, or a whole lung, or consecutively the lobes of one lung, sometimes one or more lobes of both lungs. It is therefore "lobar," and is usually unilateral.	3. Inflammation, as a rule, involves disseminated lobules of a lobe, seldom the whole of it, and practically never simultaneously all the lobules of a lobe, a lung, or both lungs, is therefore lobular and is usually bilateral.
4. The inflammation is characterized by well marked stages: (a) congestion of the pulmonary and bronchial circulation; and (b) red hepatization or the exudation in o the alveoli of a highly fibrinous material, holding in its meshes red and white blood corpuscles, a few altered epithelial cells, filling the alveoli and partially distending them, so that the whole lobe, or lung, is usually enlarged, the contents seldom extending into the terminal *bronchioles* or *lobular tubes*, and rendering the affected area airless; and finally (c), the retrograde physiological metamorphosis of this exudation, and its ultimate absorption, if life is prolonged, or rarely in local abscesses, purulent infiltration, or fibroid development, or gangrene.	4. While there are stages of congestion and exudation, they are not so typical. There is usually associated in the lung tissue "congestion, œdema, emphysema, collapse and pneumonic consolidation." The morbid product filling the alveoli is more nearly allied to the secretion of a catarrh than the exudate of a phlegmonous inflammation. It consists mainly of the catarrhal contents of the bronchioles drawn into the alveoli by suction; of epithelial cells from the walls of the alveoli, of leucocytes and rarely red blood corpuscles and fibrillated exudation. The main difference in the inflammatory products is less fibrinous material and blood corpuscles, especially the red, and more of the epithelial elements.
5. The secondary pleurisy as a rule,	5. The secondary pleurisy circumscribed, as a rule resulting in permanent circumscribed adhesion. The bronchitis may be, and usually is,

when present, is of corresponding area with the pulmonic inflammation. The bronchitis, when present, confined to the pneumonic area, and is always secondary to the pneumonia, and rarely involves deeper structures than the mucous membrane, and does not lead to peri-bronchial inflammation nor bronchiectasis

6. Prevails, as a rule, as endemics or epidemics, at all times, seasons, latitudes and countries, occurring often without apparent cause, and leaving in the same way. These endemics and epidemics are characterized by mildness or severity the same as other infectious diseases. It seldom occurs sporadically, and is never *produced by exposure to cold.*

7. As a rule, there is no correspondence between the extent of the local lesion and the constitutional symptoms; the mode of death, as a rule, is asthenia or heart failure.

general, is primary to the pneumonia, and causes the latter. It may involve the entire structure of the tube and peri-bronchial structures leading to fibroid development of the connective tissue, and therefore to bronchiectasis.

6. Never occurs as an endemic or epidemic, except when due to endemic or epidemic diseases having bronchial catarrh as an anatomical lesion or sign, or frequently complicated by bronchial catarrh, and geographically corresponding with the latter disease when occurring as a primary disease. It often occurs sporadically and is the result generally in such cases, of cold, the latter first producing bronchial catarrh.

7. As a rule, the constitutional and local symptoms are measured by the extent of the local lesion. The mode of death is by apnœa.

There are many other differences, but the above, I think, is sufficient to demonstrate the radical difference between the two forms of pneumonia. No death certificate is complete by assigning the cause of death to "pneumonia," without a qualifying adjective giving the form.

My object in reading this paper is to give my experience in the treatment of some two hundred cases of croupous pneumonia occurring among the convicts at the prisons at Pratt mines. The experience covers a period of about eight and a half years. It is not my purpose in this paper to burden you with statistics or details, but will discuss the subject in a general way, leaving the statistics for a future paper.

These convicts are worked in the mines, and at work incident to mining. Therefore, we have "inside" and "outside" men.

That you may be informed as to the sanitary condition of the prisons, and the personal hygiene of the convicts, I will briefly give you an outline of these conditions, as they were eight years ago, and as they are now. Eight years ago the sanitary condition of the prisons and the hygiene of the convicts were just about as bad as could be. Deficient in cubic space, light and ventilation, filth, dampness and overwork were the main features of the bad hygiene. At present, and for the

last six years, these conditions have been greatly improved, so that at the present time, in the language of Dr. Wines, Secretary of the National Prison Association, we have "the best cheap prisons in the United States." The sanitary condition during the past three years has been most excellent. The morbidity and mortality have been greatly reduced. For the five years ending October 1st, 1883, the death rate was 12.66 per cent. per annum; from October, 1883, to the present time, about 5 per cent. per annum. This demonstrates the wonderful reduction in death rate during the last eight years.

THE RELATION OF PRISON LIFE TO CROUPOUS PNEUMONIA.

For twenty years, ending October 1st, 1889, croupous pneumonia was the cause of death in 19.33 per cent. of the deaths in the Alabama penitentiary, due to disease. It thus appears that croupous pneumonia has caused the death in nearly 20 per cent. of the whole number of deaths—three times as much as under ordinary circumstances, according to Juergensen. There can be no question, therefore, that prison life, so far as Alabama is concerned, predisposes to the development of croupous pneumonia. In fact, all prisons, both military and civil, as well as active military life, predisposes to this disease.

Thus, during the war between the States, out of every 1,000 deaths among United States white troops, pneumonia was the cause of death in 11.84 per cent., and of the United States colored troops of 20.13 per cent.—the latter just about the same as in the Alabama penitentiary. Also, in certain commands of the Confederate armies, 20.6 per cent. (See Medical and Surgical History of the Rebellion, Part III.)

The explanation of this fact is usually made by assigning it to unsanitary conditions, bad hygiene, and to bad physical condition. I so explained it in my report in 1883 and 1884, as physician of the penitentiary. Such an explanation, however, falls to the ground in view of the facts as I have found them at Pratt mines. Thus, from June, 1883, to October, 1884, of the whole number of deaths at the Pratt mine prisons, croupous pneumonia was the cause in 16.60 per cent; from October, 1884, to October, 1886, 11.47 per cent.; from October, 1886, to October, 1888, 27.27 per cent., and from October, 1888, to Oc-

tober, 1889, 40.54 per cent., the average for the whole period being 22.94 per cent.

We thus find that the percentage of deaths due to pneumonia has more than doubled under the greatly improved sanitary conditions. In fact, the more we have done to improve, the greater has been the fatality from this disease. All other diseases—diarrhœa, dysentery, typhoid fever, continued fevers, etc.—have been practically abolished; but croupous pneumonia, until the last year, has remained with us.

This is certainly anomalous, and in strong contrast with the usual explanation of the causes of this disease. I certainly can make no explanation.

There are certain facts, however, which throw some light on the question. Our statistics demonstrate that there is much more sickness among those recently received than there is among those who have been committed for some time. The mortality is also greater. Prior to 1884 the mining prisons were largely recruited from the plantation prisons and from the penitentiary at Wetumpka, thus receiving convicts who had become more or less habituated to prison life. Since that time most of the convicts come directly from the jails. Again, from June, 1883, to October, 1884, most of the cases were of a mild type, and did not occur in groups as an endemic. Since October, 1884, most of the cases have been unusually severe, and occurred as endemics. I, however, can offer no explanation for these facts. My experience has led me to regard the essential cause of croupous pneumonia as not being dependent on bad sanitary conditions for either its production or maintenance. While these conditions may aggravate the influence of the germ, the latter can be developed and live under opposite conditions.

THE RELATION OF MINING COAL TO CROUPOUS PNEUMONIA.

From October, 1868, to October, 1880, the convicts were worked mostly on railroads and farms. Since that time the majority have been worked in mines and work incident to mining.

During the first, or farming and railroad period, croupous pneumonia was the cause of death in 19.20 per cent. of the whole number of deaths due to disease; and during the second

period, *i. e.*, mining, 19.46 per cent. We thus see that there has been practically no increase since the convicts were put in the mines.

Again, an analysis of the cases at Pratt mines show a larger percentage among the outside convicts than among those who work in the mines. Finally, during the past eight years at Pratt mines, I have not observed, nor do I know of a dozen cases of croupous pneumonia occurring among the free miners, or free people (a population of about 4,000).

These facts are antagonistic to the generally accepted views of the profession, and to me is the most perplexing problem with which I have been confronted.

OUTLINE OF PERSONAL HISTORY OF THE CONVICTS

[Data obtained from examination of convicts when received from jail.]

About 80 per cent. were negroes; 60 per cent. farm laborers; a large majority absolutely illiterate; only about one-fourth had fine muscular development; a little more than one-half had a good constitution. A bad and doubtful prognosis was made in 18 per cent.; a little more than one third had bad family history; a little more than one-third were actually diseased when received; one-fourth were under twenty, and nine-tenths under forty years of age.

The above data were obtained from the examination of convicts when received from the jails, and are compiled from the individual examination of 1,229 convicts.

These facts demonstrate that the average physical condition of the convict population of Alabama is not nearly so good as the outside population.

Of the 200 cases of croupous pneumonia, nearly all were negro males between the ages of twenty and forty years. Very few of the white convicts had the disease. Only one female out of an average female population of about ten.

The records, here, at other prisons in Alabama, and of the late war, demonstrate that the negro, under more or less unfavorable environments, is particularly predisposed to pulmonary disease in all its forms, particularly pneumonic inflammation.

They also demonstrate that these diseases are much more

fatal among negroes than among the whites. The only explanation that I can offer is, that the negro is mentally and physically inferior to the white, and, therefore, less capable to resist the invasion of disease, and to overcome its action when once developed. In addition, the negro has a hypo-cranial and thoracic development, and consequently a hypo-cerebral and pulmonary capacity when compared with the white.

Croupous pneumonia has been with us endemic, and that there has been some occult condition or conditions that have developed and maintained the essential cause of this disease, there can be no doubt. The action of this essential cause has been, at times, inoperative, at others active. Sometimes for months there would be no cases, when, all at once, without warning and without the least visible modification of the sanitation of the prisons or the hygiene of the convicts, five, ten, or fifteen cases would occur in a few weeks, sometimes four or five in one week. I have come to regard one case as a certain indication of many. These things happen, the pneumonia appearing and disappearing without the least visible reason. Season, however, seems to have some influence—May, June and August being the months in which they have usually occurred. There have been a series of cases also in September, once last year. October, November, December and January have been peculiarly exempt from these usual epidemics. There have been a great many cases in February, March and April—more in the latter than the two former—but the first months mentioned have been particularly fatal months. July ranks intermediate between the first three and the remaining months. Not only has June and August been the months of greater frequency, but also of greater fatality.

The cases occurring in the fall and winter months have been less fatal.

CLINICAL HISTORY.

There have been many peculiarities in the clinical history of this disease in many of these cases, when compared with the text-books. Pain, cough and rusty sputa have been absent in many cases—sometimes one, sometimes all three. In many cases, particularly those in which pain was absent, the crepitant rale was not heard. In many cases the evolution of

the inflammation was delayed for several days, from three to six, as determined by the physical signs.

The most characteristic symptom, and the one always present, was the extremely sick condition of the patient. All were characterized by great prostration, muscular debility and general weakness. As a rule, the onset of the disease has been sudden, without premonition. Generally a chill, more frequently chilly sensations, then a rigor, occurring usually at night, followed by high fever, fast breathing, general prostration and apparent gravity of disease. Pulse, 120 to 140; temperature, 104° to 106°; respiration, from 36 to 50. Constipation the rule. Nausea or vomiting rare. Delirium has been rare. Wakefulness and restlessness the rule. The absence of pain and cough I account for by the absence of the consecutive bronchitis and pleurisy. The rusty sputa, when absent, simply demonstrates that there is no hemorrhage in the exudate, and but few red corpuscles; or it may be, in those cases where there was no cough, the absence of the latter explained the want of the rusty sputa. Nearly all, however, had cough before the end of the case, and the majority pain also. But in many cases there was no rusty sputa, and in some sputa of no kind.

The physical signs in many cases were negative for several days. In some cases there were slight signs of disease, a slightly elevated pitch of the percussion note, a slightly diminished respiratory murmur, with a very slight broncho-vesicular quality, a slightly increased vocal resonance, with, as a rule, no increase of vocal fremitus, characterized the delayed cases. In others, the physical signs were pronounced and typical from the beginning. In those cases in which the physical signs denoted delayed evolution of the inflammatory process, the disease was longer in duration, and more fatal than the more typical cases.

In the majority of the cases that recovered, crisis was the termination—a few by lysis. In most instances, simultaneously with the end of the constitutional symptoms, or very soon after, resolution set up. In some the physical signs remained unchanged for two days, and in a few cases for weeks, and in two cases two or three months.

The portion of the lungs involved, and the extent of the lesion, differs widely in recent and former years. In the first fifty cases, only a small percentage were double, and, as a rule, a lower lobe, particularly the right, was the seat of the local lesion. After this, the tendency to double pneumonia and to involve the upper lobes increased, so that during the last four years over 50 per cent. of the cases were double, and nearly 75 per cent. involved an upper lobe, generally the right, and in a few cases the entire lungs were simultaneously involved, death closing the scene in twenty-four to thirty-six hours. In others the lobes of both lungs were successively attacked, so that at the post mortem all the stages of the disease could be demonstrated. In a few cases the patient, however, recovered —resolution successfully following the invasion.

Complications were also more frequent during recent years. Meningitis, pericarditis and cardiac thrombosis were the most frequent complications. In many, the disease occurred in those affected with chronic diseases—rheumatism, organic heart disease, scrofula, etc. I do not believe, however, that these diseases predisposed to the development of the disease, but, of course, increased the fatality.

MORTALITY.

I can give only accurate data up to October, 1889, as I have not had the time to compile the statistics during the last two years. Up to October, 1889, there were 155 cases and 50 deaths, or a mortality of 32.25 per cent. Since October, 1889, the relative mortality has been a little less, which would make the mortality of the two hundred cases about 30 per cent.

Studying this mortality for different years it ranges from 12 to 30 per cent. thus demonstrating the difference in the severity of the various series of cases.

In nearly all these cases severe complications were present and generally the pneumonia was double, and in the vast majority the upper lobe of the right lung was involved. In most of the cases the upper and lower lobe of the right lung and the lower lobe of the left. In only a few was the middle lobe of the right the seat of disease. Meningitis and pericarditis (not speaking accurately) was present, each in 4 or 5 cases.

In one case both were present. Cardiac thrombosis, or heart-clot, almost always present, the physical characters of which demonstrated in many instances that it had existed for a considerable time, and was not developed while the patient was in articulo mortis or post mortem. In nearly all there were old adhesions, in some, throughout, in most of them, posteriorly, demonstrating previous attacks of pleurisy or pneumonia. In the majority there were a few recent adhesions, and generally the pleura was covered with lymph corresponding to the inflamed pulmonary tissue, particularly that part of the lung in which the pneumonia was in the second or third stage, rarely when in the first stage. In some there was no signs of pleurisy whatever, either old or recent, and the lungs could be turned out like a liver.

The appearance of the lung itself depends of course upon the extent and stage of the inflammation. The majority died during the second stage of a whole lung or one lobe of each lung, with the first stage in one or more lobes, sometimes the whole lung.

Purulent infiltration rare; abscess nor gangrene has been observed. Œdema always present, usually confined to the pneumonic area, but not infrequently the healthy lung, when there was any, was also œdematous. In a few instances the pneumonic inflammation was in the third stage, resolution progressing, the patient dying from the complication. In two cases the patient entirely recovered, so far as the pneumonia was concerned, subsequently dying from pulmonary infarction and embolism of the arteria innominata. Heart clot existed in both of these cases. One portion of the clot in the right ventricle was dislodged and conveyed to the lungs and gave rise to a series of attacks of embolic pneumonia, with clinical history resembling intermittent fever, which diagnosis was first made, finally dying from exhaustion. The lungs were full of embolic consolidations and an old firm clot in the right ventricle. In the other, resolution was complete, the heart remaining fast and irregular, when the patient suddenly became violently ill with symptoms of dyspnœa and coma and died. Post mortem showed a firm clot easily removed from the arteria innominata and right subclavian and common carotid arteries. Resolution in both lungs complete.

I will not worry you with a further analysis of these cases, but will proceed to discuss some points which may be of interest.

The great prostration is undoubtedly largely of nervous origin and is due largely to the essential cause of the disease. The violence of the symptoms in those cases in which the physical signs are practically negative for several days, showing that there is no active exudative inflammation at that time, and the further fact that physical signs show solidified lung, often after all constitutional symptoms have subsided, demonstrate the constitutional nature of the disease and that the constitutional symptoms are not merely the *expression* of a local process. Yet according to my experience in the majority of cases, the constitutional, as well as local symptoms, are more severe in those cases with extensive local lesion—not always *pari passu*, but approximatively. I therefore cannot agree with those authors who teach that there is no connection or parallelism between the local inflammation and the general symptoms It is true that cases involving only one lobe are sometimes unusually severe, but I have never seen a case of double pneumonia in which the constitutional symptoms were mild. In those cases in which the pneumonia is central, that is, invades the pulmonary tissue from centre to periphery, I have found to be the most dangerous. These are the delayed cases and those in which we have the physical signs enumerated above.

My explanation of this is, that there is really more vesicular surface involved than when the disease commences on the periphery. The air cells are smaller than at the margins, borders and periphery of the lungs, thus in a given cubic area of lung, multiplying the diameters and consequently the circumferential area, and hence the aggregate vesicular surface becomes increased. Therefore, in a given cubic area of lung in which the cells are smaller, there is more vesicular space than in a like area, where the cells are larger.

This being true, the inflamed surface is much greater and the respiratory function correspondingly embarrassed. I found in these cases of central pneumonia in which the exudation was fully developed, that portions of tissue cut from the

margins and periphery would not sink in water and showed signs of crepitation On the other hand, in those cases in which the periphery was first involved there were no signs of crepitation there, and portions cut from it would sink in water, and showed some signs of crepitation.

This explanation, of course, contradicts the idea that a whole lobe is alike involved, and to this latter idea I am inclined, because it is very rare that a whole lung or whole lobe, notwithstanding it is involved in the pneumonic process, even in the second stage, will sink in water, or that does not show circumscribed areas of slight crepitation.

I therefore believe, that in central pneumonia, for the reasons given, there is a greater extent of vesicular surface involved. It is in these central cases that the crepitant rale is often absent and in which there is often no consecutive pleurisy.

I am, therefore, inclined to the belief that the crepitant rale is often caused by the pleurisy, as some teach, and not by the separation of the adhered vesicular surfaces. The absence of pleurisy also explains in these delayed cases, the absence of pain, and possibly cough, also, when it is absent. In fact, I believe the cough is mainly due to the consecutive bronchitis, as well as most of the expectoration and the pain, as all agree, to the pleurisy.

Heart clot I think, is more than a mere sequence of articulo-mortis or post-mortem changes. I believe it is often a veritable complication and is in many cases the immediate cause of death. That is to say, that many cases would recover were it not for the formation of these clots. I know that some of the clots in my possession ante-dated death by several days. They were firmly attached to the columnæ carnæ and chordæ tendinæ and musculi pectinati, often extending into the aorta and pulmonary arteries; in a few instances into even the innominate artery. They can be pulled apart like the layers of an onion, in fact, possess all the characteristics of thorough ante-mortem clots.

There can be no doubt in my mind as to their often being the direct cause of death, in otherwise favorable cases.

In corupous pneumonia we have all the essential conditions

for the formation of heart clots, which I will not take up your time to enumerate.

The lungs of convicts who worked in mines were blacker than the normal or pathological condition in pneumonia. This is due to deposit of coal dust in the connective tissue, a kind of latent anthracosis. This condition, in my opinion, predisposes to an increase in the extent of the pulmonary lesion and also crippled the lung in such a way as to modify unfavorably its capacity to recover. Therefore, we can expect a larger mortality among a mining population who have pneumonia.

The prognosis of pneumonia depends upon the character of the epidemic for mildness or severity; the presence or absence of complications, the type of the disease and, in my opinion, very important, the extent of the pulmonary lesion.

The treatment of croupous pneumonia is up to this time a disappointment. There is no specific for the disease, no antiseptic that will destroy the essential cause when active in the body, no system nor plan nor method, consisting of various features, whether sedative, stimulant or mixed as yet devised to treat this disease with success.

I know of no method that will abort or even modify the pulmonary inflammation. These views are pessimistic, but unfortunately true. Notwithstanding, life can sometimes be saved by judicious treatment. In estimating the results of treatment, numerical statistics alone prove nothing. Unless the nature of the epidemic, the extent of the local lesion and the presence or absence of complications and their nature are fully understood and their influence estimated, mere statistics and percentages are worthless.

My experience has taught me that the mild uncomplicated cases and of limited extent, say one lobe, preferably a lower lobe—intrinsically tend to recovery, and nearly all will get well, barring the influence of age and bad physical condition, etc., with or without treatment. On the other hand the severe cases, characterized by high fever, fast pulse, fast and imperfect respiration, with considerable dyspnœa and great extent of tissue involved, say one lung or one lung and one lobe of the other, especially if complicated, intrinsically tend to death, and the majority will die with any treatment whatever. In

my opinion, aconite, veratrum, purging, tartar emetic and any and all depressing agents have no place in the treatment of this disease. The main object in treatment should be to modify the depressing effects of the morbific influence, which is best done by the judicious administration of opium, to reduce the temperature, which is best done with large doses of quinine, from 20 to 40 grains given at once; to sustain the vital powers with alcoholic stimulants and plenty of nutritious diet. Medicinal stimulants may also be given, of which digitalis stands at the head of the list, strychnine next. According to my experience carbonate of ammonia is useless, but I generally give it as a matter of routine. The local treatment is very simple. Turpentine stupes, or any mild counter irritation will answer—enveloping the chest with cotton, over which oil silk is neatly fastened, will do in cases of children. Blisters, in my judgment, have no more influence in modifying the extent or course of the inflammation, than they would the lesions of Peyer's patches in typhoid fever. Blisters, therefore, in my opinion have no place in the treatment of this disease.

Special symptoms and conditions must, of course, be met. Œdema is often an immediate cause of death, and can sometimes be relieved. This is best done by extensive dry cupping and an increase of the stimulants. Bronchitis when present should be appropriately treated with stimulating expectorants.

I will not consume more of your time in discussing the treatment of this disease.

In concluding allow me to impress upon your mind that croupous pneumonia is a general, constitutional, infectious disease, with local lesions in the pulmonary parenchyma, and that the usual treatment for true inflammation is not applicable to the treatment of this disease.

THE CURE OF EPITHELIOMA.

W. S. GOTTHEIL, M. D., NEW YORK.

The existence of a carcinomatous element being recognized, the question as to the most appropriate treatment for it at once presents itself. And whilst there may be much divergence of opinion as to what this treatment should be, on one point we are all agreed, viz: That it should aim at the complete removal of every particle of epitheliomatous tissue—of every single outlying cell that may have felt the influence of that mysterious stimulus that has awakened it into a life of such pertinaceous activity. For experience teaches the probability of the fact that the leaving behind of a single one of these cells will inevitably lead to the recurrence of the disease.

Hence, we can at once cast aside a number of methods of treatment which have been recommended. All manner of internal medication is absolutely useless. No drug has ever been known, and, so far as we can foresee, no drug will ever be known, the ingestion and assimilation of which has the slightest effect on epitheliomatous tissue. It is true that there are cases recorded to the contrary. Many patients—and alas! also some physicians, tell us of the wonderful results they have seen in the "melting away" of skin cancers under the exhibition of certain remedies. Only recently I received the assurances of an old and esteemed practitioner of the wonderful effects of a well advertised patent medicine in a case of fungating epithelioma. The error is either one of observation, and the growth has not improved during the medication, or the diagnosis is at fault, and the new growth was really a tubercular ulcerative syphilodema. The alleged skin remedy in question undoubtedly contains mercury and iodide of potassium; hence its action on "syphilitic cancers" is not a matter to be wondered at.

In the same way we can cast aside without examination all local remedies that are anything less than deep escharotics. No matter how early we begin the treatment of our epithelioma, we are already dealing with a dense mass of proliferating

epithelioma, the superficial layers of which afford a very efficient protection to the deeper cells against any superficial injuries.

We shall therefore waste no time in painting the tumor with Fowler's solution or applying salicylic acid in solution, or stick of nitrate of silver, or bluestone. These things are not only useless—they are absolutely harmful. They exert whatever slight amount of destructive power they may possess on the superficial layer of the growth only; whilst on the deeper and rapidly growing masses they act as a direct stimulant, exciting them to more rapid and more vigorous growth. They not only do not destroy the cancerous tissue—they directly favor its growth.

There remains then as worthy of our consideration only the more radical and deep-reaching methods. These consist of:

1. The knife.
2. Electrolysis.
3. The sharp curette.
4. Escharotics.

Each one of these methods has its enthusiastic advocates. Each one of them is undoubtedly the best in certain cases. A wise eclectricism is the most rational plan. Let me try and indicate in what class of cases I have obtained the best results from each of them.

1. The patient invariably objects to the knife. Whether this fear is legitimate or not on his part matters little. It is a factor with which we have to deal. Cæteris parilus, he will be most successful in treating his cases who uses the knife least. Nor is the fear of the necessary anæsthetic without weight in the patient's mind. But there is another and more serious objection to the knife, and one which should have more weight with the physician. The mode of growth of the epithelial mass is a peculiar one. The cells grow in nests, which form arms and projections that invade the surrounding tissue. It is only when they have accumulated in large quantities that they begin to form the characteristic pearly elevations that betray the presence of the disease to us. Hence there are always outside the apparent limits of the disease areas of skin that have already been invaded by the cell-nests. Of the

extent of these the surgeon has no means of judging. He cannot tell where his incision should be made. However far outside the apparent limits of the neoplasm he may make his mark, he is still liable to cut off and leave behind projecting arms of the epithelioma, which will soon form new centres for malignant growth.

Thus it happens that relapses are more common after excision than after any other radical measure. This, together with the patient's years, form the main objection to this plan of treatment.

Nevertheless, in a certain class of cases it is the most available and perhaps the only plan. This is the case in all cases where the epithelium invades or is in very close proximity to the mucous membrane at one of the natural orifices. Here some of the applications to be hereafter mentioned cannot be used on account of their poisonous nature, and the danger of their absorption; and others again cause so much inflammatory action in their immediate vicinity as to endanger important organs.

So we prefer the knife in all epithelial carcinomata that involve the angle of the mouth, or the lips; in all that impinge upon the orifices of the nostrils, or the upper or lower eyelids. Here excision, as far as we possibly can through the mucous membrane and skin beyond the apparent limits of the disease is our best plan of treatment. Nevertheless, even in these cases it is frequently possible, and always advisable where it is possible, to treat the parts of the tumor furthest removed from the mucous membrane by one or other of the methods to be described below.

Local anæsthesia is rarely sufficient where the knife has to be used. Etherization is required, and this adds to the unpleasantness of the process.

2. For small beginning epitheliomata, those that are no larger than a large pea or a bean, there is no more eligible mode of treatment than by the electrolytic needle. The method appeals to the patient; removal by electricity seems desirous to him. There is but little pain connected with it—anæsthesia is not necessary.

A galvanic battery of at least 20 cells, a few fine watch-mak-

er's brooches and a needle-holder, are all the instruments that are required. The process is exactly the same as that employed for the electrolytic destruction of the hair papillæ. A rheostat or a milliampremeter may be used, but are not necessary. The amount of burning the patient feels and the amount of local reaction that you see at the needle's end, are quite sufficient indices of the strength of the current. In a general way, with a freshly-filled battery, six or seven cells in the circuit is quite enough.

The needle should be well sharpened on an oilstone before introduction, the amount of pain inflicted depending largely on the condition of its point. The needle-holder is attached to the negative pole of the battery, whilst the patient completes the circuit with a sponge electrode attached to the positive pole, at the word of command.

It is important that no mistake be made between the battery poles. If perchance the needle should be attached to the positive pole, and the circuit completed, there would be no destruction of tissue around the needle point, but an oxidation of the needle and the deposition of black particles of oxide of iron in the tissues—a tattooing. It is always easy, however, to distinguish the poles. Immerse the metallic ends of the conducting cords in a glass of water; the end upon which the bubbles of gas form is the negative—the decomposing pole.

The patient holds the handle of the positive electrode in one hand, ready when the word is given to complete the circuit by applying the sponge to the palm of the other hand. The needle is now inserted into the skin just outside the base of the tumor, and passed obliquely through it. The word is given and the current is completed. A burning is felt by the patient at the site of the needle, and minute bubbles of gas appear at the point where it penetrates the skin. The current is allowed to act for a minute or two; the word is given, and the patient breaks the circuit by withdrawing the positive electrode from the palm of his hand. Then, and not till then, the needle is withdrawn. It is then inserted at the opposite end of the tumor, and the process is repeated. This transfixion is done from all sides, taking care each time to introduce the needle into apparently healthy tissue just outside the

evident limits of the growth. Finally, as the blood supply becomes entirely cut off, the tumor assumes a yellowish appearance; it is filled with gas from the decomposed tissue, and crackles when touched. The entire mass is dead. In a day or two it turns black and is cast off.

No method is more convenient and less painful than this for the destruction of epitheliomatous tumors of small size. The only point needing attention is to exercise care in including a sufficiently large area around the tumor in the destructive process to include all outlying epitheliomatous process.

3. The curette alone is rarely sufficient to complete the cure of an epithelioma. Larger masses of cancerous tissue can be rapidly removed by it, and with a minimum of pain. But it is impossible, save in the cure of a very small growth, to clear out all the rancified epithelial process by this means.

Instruments of various size, known as dermal curettes, are to be employed. Those with large and solid ebony handles, roughened to permit of firm grasping, are much to be preferred to the so-called aseptic instruments with flat steel handles; since these latter are unhandy to use and liable to slip. Three sizes are required, the largest to rapidly remove masses of tissue, the small ones to go down with into the deeper parts of the growth. The cutting edges of the curettes should be smooth and well-sharpened.

Local anæsthesia is almost always sufficient. Cocaine applied externally, or injected into the periphery of the mass in various places, will do. But a local anæsthetic composed of menthol, 1 part; chloroform, 10 parts; sulphuric ether, 15 parts, has given even better results in my hands.

The patient's head is now steadied by an assistant, a mass of absorbent cotton is held with the left hand just under the site of operation. With rapid motion and considerable pressure, the soft, new growth is scraped away. There need be no fear of going too deep. Healthy tissue offers so much greater resistance to this as "prattage," that there is no difficulty in deciding when we come to them.

It is useless to stop after the operation has once begun to apply more of the anæsthetic. These tumors are frequently very vascular, and the blood washes away the remedy. The

curetting should be rapidly and thoroughly done when once commenced.

As I have said above, the method is good in its way, but is insufficient alone. There is no more certainty than there is with the knife, that the entire mass has been removed. It must rapidly and thoroughly remove large fungating masses; but it is my invariable rule to follow it up by the fourth method, to be now described.

4. *Escharotics.* These remedies for cancers of the skin have long lain under a cloud undeservedly. The advances of modern surgery have cast into obscurity methods

[TO BE CONTINUED]

MALARIAL HÆMOGLOBINURIA—ANSWER TO DR. PARHAM.

I regret that absence from the city prevented my answering Dr. Parham's article last month. The doctor states he is not aware that the above disease is not a hemorrhage, no matter how confident I may speak on the subject; that it has all the characteristics of a hemorrhage discoverable without the aid of a microscope; in which he is perfectly correct, and for the same reason the disease has been erroneously treated as a hemorrhage for many years. If there is any way that an absolute differential diagnosis can be made between hæmaturia and hæmoglobinuria without the aid of the microscope, I wish the doctor would publish the secret, as he is the only one that possesses it. Until then, as he acknowledges that he has no availed himself of the only known way in which the diagnosis can be made, it seems only reasonable that he should allow a certain amount of credence to the reports of numberless good scientists who have made this examination, and without a dissenting voice pronounced it a hæmoglobinuria.

The doctor takes me to task for using preventive medication, and for treating a disease before it exists. I had hoped that the following, as it occurs in my original article, was explicit enough to be understood by a first-course student, as I can't see how a disease can be treated before it is diagnosed: "I should advise, as soon as the case is diagnosed, a sufficient

dose of quinine to cinchonize the patient, say thirty grains in solution, or its equivalent hypodermically."

I can say now, after some years' experience, that preventive medication is of great value in the disease. The doctor asks what malaria is. He might as well ask what scarlet fever or typhoid fever are, or, better still, tell me what morbid secretions are. The *modus operandi* of quinine, as has been observed by competent scientists, is to cause the disappearance of the intra-corpuscular bodies in the red blood corpuscles which occur at the beginning of the paroxysm, and probably go on to the complete destruction of the invaded corpuscle when not influenced by medication. This action has been observed since my original article. The number of corpuscles invaded and destroyed before any medication is given probably accounts for the invariable fatality of the pernicious cases of this disease. The doctor may deny that quinine has any control over malaria; that is his opinion; but in the present status of the question it will require some new facts to shake the belief of the profession in this action of quinine, and without such facts there can, of course, be no argument on that issue.

In regard to ergotole, I am sure that I do not know what the doctor intended to say. He did say, "I control the hemorrhage and alter the abnormal condition of the blood with the following: Ergotole, tinct. iron, aa gtt. x." Which is an absolute assertion with, as far as I can see, no opening for escape. The evacuant pleasantry was the result of a typographical error in the doctor's first article. I asked the doctor to furnish me with some statistics of this disease, accurately observed, before the publication of my original paper. He furnishes me with some recollections of the disease, of no scientific value, but still presenting some peculiarities.

He has had one hundred cases with only one death, and that, we are led to infer, died of heart disease, consequently he has had ninety-nine consecutive recoveries. All of them of the continued type of fever.

Other observers look upon the continued type as the rare form of the disease. His treatment varies in no essential from the treatment that has been used for the past fifty or

one hundred years. In all available statistics the mortality is from thirty per cent. up, as the course of the disease and the result of the treatment is so decidedly at variance with all other observers, it would lead one to suppose, taking these two factors into consideration, that there might have been some error in diagnosis.

There is a late paper by W. T. Prout, M. D., C. M. Edin, goverment officer, Gold Coast, W. Africa, (*Lancet*, Aug. 1st, 1891) on malaria, that is of interest to all students of this disease, from which I quote as follows, as bearing special reference to the subject in question.

"The third type is the hæmoglobinuric form, which is fortunately the rarest, as it is the most severe and most dangerous. It rarely occurs in Europeans who are in robust health, but in those who have become debilitated and anæmic from repeated attacks of fever, or from mental worry or alcoholic or other excess. I am inclined to associate it more particularly with any cause which interferes with the action of the liver, as I have seen it occur several times in beer-drinkers. The onset is sudden, accompanied it may be with slight shivering. Vomiting commences early, and is a prominent and intractable symtom throughout. At first it consists of bile, and laterly merely of the liquids imbibed, mixed with dark green shreddy particles. The tongue and breath are foul, and there is great thirst. The skin, conjunctivæ, and buccal mucous membranes are of a bright canary-yellow color. The temperature need not necessarily rise very high, and may even fall to normal, though the other symptoms persist. If after this there is a constantly rising temperature without remission, the prognosis is unfavorable. The state of the urine early attracts the patient's attention. In the worst cases it is a dark porter-like color, is almost syrupy in consistence, frothes easily and stains the sides of the vessel containing it a bright crimson. At this stage boiling and nitric acid show the presence of a considerable quantity of albumen. A copious deposit forms on standing, which is seen to consist of pigment granules and pigment casts from the kidneys. A few blood-cells may be present, but they are not common. The quantity of urine is usually diminished. Recovery may

take place, and in this case the general symptoms improve, and the urine gradually becomes less high colored, increases in quantity, and becomes loaded with urates. Convalescence is naturally slow, and departure from the coast is usually indicated. On the other hand the symptoms may become aggravated; the urine diminishes in quantity, although the color generally improves, and total suppression may take place. Death in these cases results in from three to five days from uræmia and exhaustion."

With reference to the time of occurrence of these bodies, it may be observed generally that the intra-corpuscular forms were present before the paroxysm and while the temperature was rising, and usually disappears under treatment.

The effect of quinine in the cases in which I was able to make several examinations, appeared to be the disappearance of the intra-corpuscular bodies.

The effacacy of quinine in the treatment of malaria is a point on which some doubt has recently been thrown, but the more I have to do with this disease the greater becomes my confidence in the judicious administration of quinine, which, so far as I am able to judge, is the only drug which can be relied upon to cure malarial fever.

There is no doubt that malarial fever, like many other diseases, has a tendency to be self-limiting, but it does not follow that quinine is of no use because certain cases recover without the administration of any drug. I myself have treated many cases of intermittent fever among coolies in Mauritius with a simple infusion of quassia, or sometimes have given them no treatment, and have found the fever gradually disappear. That, however, only holds good when the vitality of the tissues, and principally the blood tissue, is sufficient to cope with the malarial poison; but where the vitality of the body is lowered by any cause, or where the quantity of poison absorbed has been very great, I find quinine can be relied upon to cut short the attack.

Quinine can only be regarded as a poison to the malarial organism, killing it and preventing its further development. There are no doubt certain cases in which quinine fails entirely; but they are rare, and I believe are not pure cases of

malarial fever, but probably connected with some obscure complication often connected with the state of the intestines.

It appears to me to be a reasonable position to take up that if quinine is antagonistic to the malarial poison, the administration of small doses, say two or three grains daily, will be inimical to the development of the organism, just as a two per cent. solution of carbolic acid retards the growth of the spores of the anthrax bacillus, although a five per cent. solution is required to kill them. I can quote only one case, namely my own, which of course has little weight by itself. For a period extending over several months I used small doses of quinine without any evil effect, and with the result of keeping me fever free, while after I ceased to take it, I suffered from a mild intermittent within three weeks.

Should Dr. Parham offer any new points on the pathology, clinical history or treatment of this interesting and dangerous disease, I shall be glad to continue this discussion, otherwise I beg to decline. Should any of the readers of this journal deem it of sufficient interest, I shall be glad to furnish them with copies of my original article, a few of which I still have on hand.

BASSINI'S RADICAL CURE OF HERNIA.

At the recent congress of German surgeons, Dr. Escher, of Trieste, reported his results from this method of operation. It consists in laying open the inguinal canal over its entire extent and somewhat beyond; the spermatic cord and hernial sac is then lifted up, and the latter incised up to its neck, and then ligated, excised and the remaining portion replaced. The layers of the internal oblique and transversalis muscles are then carefully isolated, as well as the internal portion of Poupart's ligament, and the edges of these structures are accurately united by suture. The spermatic cord is saturated in this gutter, and the fascia, muscles and skin united. The author has employed this method in 53 herniæ. The results were as follows: Of the 35 cases of reducible herniae, 25 per cent. healed by first intention, 10 with suppuration; of the nine cases of incarcerated hernia, 5 healed by first intention, 3 with suppuration, and one terminated fatally; of the 9 cases of irreducible hernia, 4 healed by primary union, 4 by suppuration and one died. As regards the permanence of the cure, in 24 cases which can be utilized for this purpose, there have been no recurrences during a period of observation varying from three months to two years.—*Deutsche Medicinische Wochenschr.—Toledo Med. Compend.*

Correspondence.

NEW YORK LETTER.

NEW YORK, DEC. 21.

Dr. A. A. Smith, of this city, speaking recently on the subject of acute œdema of the lungs, said that the method of treatment he has found most successful in many cases is a combination of strychnine and atropine by hypodermic injection, and nitroglycerine by the mouth. The quantity used by him is 1-50 of a grain of strychnine and 1-100 of a grain of atropine given together, and 1-100 of a grain of nitroglycerine administered at the same time. The conditions that give rise to a pulmonary œdema, have also lessened the power of the stomach to take up medicinal agents. Nitroglycerine being so diffusible, is very readily absorbed and produces its effect very quickly and equally so when swallowed as when given subcutaneously. These doses are generally repeated in two hours. The strychnine, he says, increases the force of the heart by stimulation of its muscle, and its ganglia, as well as by stimulation of the vaso-motor centre. It is the most constant and powerful respiratory stimulant we possess. Atropine increases also the force of the heart and stimulates the vaso-motor and respiratory centres; while nitroglycerine dilates the arterial blood vessels, in this way relieving the venous conjestion. It relieves an overworked and weakened heart by its action on the arterial system, and affords an opportunity to strychnine and atropine to better produce their physiological effects.

After the first repetition, the atropine is discontinued and the nitroglycerine and strychnine are kept up every two hours until relief is afforded the patient.

Opium and nitroglycerine he has found to give the best results in pulmonary œdema occurring as a complication of acute renal disease. The sudden accumulation of poison acts on the nerve centres and on the vaso-motor nerves, interfering with their regulation of blood in the capillaries. Opium counteracts the effects of this poison, and nitroglycerine aids in the restoration of the functions of the capillaries. In

acute so-called uremic poisoning, it is not at all uncommon, when the convulsions have been controlled, and the coma relieved by opium, to find the kidneys resuming their functions. The explanation of this phenomenon is not far to seek. The nerve supply of the kidneys has been acted upon in such a way by the accumulated poison as to destroy its functions temporarily. Opium neutralizes the effects of this poison on these nerves, affords them opportunity for rest, as it were, and they resume their normal function. The dose he usually gives is 1 6 of a grain of morphia and 1-100 of a grain of nitroglycerine, every two hours until relief is secured.

When cyanosis, with pulmonary œdema, is very marked, oxygen seemed to him to give relief to the dyspnœa, if cautiously administered. He has seen difficulty of breathing greatly aggravated where pure oxygen had been administered too freely. He has had more satisfactory results when it has been given with a tube, with the patient's mouth about two inches from the orifice, mixing it in this way with the atmospheric air. In fact a patient with pulmonary œdema will refuse to take a tube in his mouth because it obstructs his efforts at breathing.

In acute general pulmonary œdema, occurring in connection with pneumonia, strychnine, atropine, and nitroglycerine have frequently given relief.

In all operations upon the abdomen performed at the New York Hospital, the following general plan is carried out: For two or three days preceding the operation, the bowels are mildly purged and the diet carefully regulated. In some few cases, where the operation is long and the conditons favorable for shock, free stimulation by the mouth or rectum is resorted to.

The parts to be operated upon are carefully cleaned with soap, water, and ether, several hours previous to operation, and a large wet dressing of 1-2000 bichloride solution applied.

The instruments are always boiled for half an hour or more previous to the operation, and during the operation they are kept in a tray containing ether, boiled water or a 1-1000 solution of hydronaphthol. The sponges are kept in boiled water, and no antiseptics are used during the operation. The

abdomen is irrigated only in those cases where there is some special indication. A small amount of 1-10,000 bichloride solution is used in a few cases where peritonitis is already advanced. The glass tube is the form of drainage generally used, but where there is any tendency to oozing from broken adhesions, a tampon of iodoform gauze is inserted alongside the tube and allowed to remain from twenty-four to forty-eight hours.

The peritoneum is sutured with a continuous catgut suture, the muscles with catgut interrupted sutures, and the skin by a separate line of interrupted silk sutures.

As soon as the patient is taken to the ward and there is any evidence of shock, the body is surrounded with hot water bottles, and hot water and whisky given by the rectum. During the first twenty-four hours, nothing is given by the mouth except a little hot water or cracked ice. Very little morphine is given in most cases. On the second day, liquid food in very small quantities is given. The drainage tubes are removed on the second or third day, and the sutures on the eighth or tenth. On the fourth day or earlier, if tympanites is present, the bowels are freely moved by small and frequently repeated doses of Rochelle salts.

Very little credit is to be placed in the sensational prophecies made in the newspapers regarding the occurrence of another epidemic of La Grippe in this city this winter. The history of epidemics of influenza shows that it does not repeat its visitations in any one locality, more frequently than every eight or ten years. The diagnosis of la grippe is not always an easy matter, and there is no evidence that the infection is as yet present in this city. The presence of la grippe is usually manifested by an increased mortality, and reports from the Health Board do not show such to be the case. The city has never been in a more healthful condition than it is at the present moment.

The following advertisement, which appeared in a recent issue of the New York Record, is full of suggestiveness for the young physicians who contemplate starting in practice in this city, and being a unique one of its kind is given verbatim.

"A young physician, practicing in this city for nearly two years, and earning less than one quarter of his expenses, desires to know of an opening where at least he can make a living."

Comment is unnecessary.

DEATH FROM ANÆSTHETICS.

In a paper on this subject published by the *Jonrnal of the American Medical Association* of August 15, 1891, Dr. Lawrence Turnbull presents the following conclusions:

"1. During the protracted use of chloroform as an anæsthetic, the blood is changed in character, lowered in pressure, with weakening of the action of the heart and changes in its structure.

"2. Dilatation of the heart occurs under the use of chloroform at all stages, on both sides of the heart, while the heart muscle is weakened.

"3. Cardiac failure occurred before respiration in thirteen instances out of forty-three cases of death from chloroform.

"4. The depressing influence of chloroform on the heart mechanism is not exerted through the vagus nerves, and section of both vagi does not obviate the weakening and dilating influence of chloroform on the heart.

"5. Two many trifling operations are performed under chloroform; its use should be reserved for those cases in which ether, nitrous oxide, or cocaine will not produce the anæsthesia desired.

"6. Ether death, as a rule, occurs in patients of a certain class, usually from obstructed respiration, and occasionally the heart will stop first, as in two of the fonr cases in our tables

"7. Watch both pulse and respiration, both in chloroform and ether; when the breathing becomes very rapid, danger is near.

"These changes are apt to follow the first act of respirati on Chloroform vapor should not be employed over 4 per cent."—*Brooklyn Medical Jonrnal.*

Society Notes.

SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION.

FOURTH ANNUAL MEETING HELD IN RICHMOND, VA., NOVEMBER 10, 11 AND 12, 1891.

NOVEMBER 11TH, SECOND DAY—MORNING SESSION.

The Association was called to order by the president at 10 a. m.

Prayer was offered by the Rev. Dr. Newton.

Dr. Thomas J. Moore, of Richmond, delivered an eloquent "Address of Welcome."

Dr. William Warren Potter, of Buffalo, New York, read a paper entitled "A Medico-Legal Aspect to Pelvic Inflammation," in which he said that pelvic inflammations in women have been described, discussed and debated from almost every point of view imaginable, until our periodical medical literature is flooded with articles on the subject, and medical society transactions are teeming and bristling with papers pertaining thereto. So far, however, he had not observed that anyone had undertaken to discuss these intra-pelvic conditions from a medico-legal standpoint. It was his purpose to present that aspect of the question, taking for his text a case that developed an interesting problem in that respect.

After giving a history of the case Dr. Potter emphasized the following points:

1. The intimate anatomical relations between the pelvic organs and the larger joints of the lower extremities, especially the hip and knee joints, render them liable to reflexes.
2. The importance of careful diagnosis at the outset, lest grave errors and possible disastrous consequences may result from treatment.
3. The medico-legal bearing that errors of judgment in diagnosis and treatment may have in relation to the patient, as well as upon the reputation of the physician.

"The Medico-Legal Aspect of Intestinal Surgery." Dr. John D. S. Davis, of Birmingham, Ala., read a paper on this subject. He said many physicians and surgeons who condemn all mechanical aids for intestinal repair, know not how to use them, never saw them used; refuse to endorse a resection for gunshot or stab wounds; have been known to go into the witness box for purposes of condemnation and disapproval when they knew no more about intestinal surgery than a wild Indian about school teaching.

In this day of specialties in medicine, but few general surgeons have either the appreciation, opportunity or disposition to qualify themselves as expert operators in intestinal surgery, but many—to the discredit of the profession—voluntarily appear in the criminal courts of the country pretending to be such—wise and proficient. One of the greatest professional sins of the day is perverted knowledge of conceited ignorance. It is too often that physicians and surgeons weaken and invalidate their opinions to a greater or less degree by unscrupulous interest in behalf of those employing them, a fact cunningly turned to advantage for defendants in criminal prosecution, and for like reason may become dangerous to the operators they oppose and envy.

To be able to do a laparatomy for stab or gunshot wounds of the intestines, inflicted by one with murderous intent, and be able to evade civil and criminal liability, the operator must (1) be able to show evidence of ordinary surgical knowledge in the requirement of the special operation to be performed; (2) he must possess ordinary surgical ability for doing the spe-

cial operation to be performed; (3) he must exercise ordinary prudence in performing the special operation to be done, as to time, place, antiseptics, asepsis, assistance, nurses and after treatment; (4) he must perform the special operation in an ordinary skillful manner. Hence to prevent confusion it will be good, if possible to determine what constitutes ordinary surgical knowledge, ability, prudence and skill. Upon these depend the whole medico-legal status of the intestinal surgeon, and upon which the expert should be required to depend also. According to the practices and rulings of courts in this country, the word *ordinary* in its surgical adjectiveness, means that the surgeon shall be capable of and exercise that surgical knowledge, ability, prudence and skill with which a fair proportion of the surgeons of his given locality are endowed, and not that of the highest lights of his profession.

Dr. John A. Wyeth, of New York City, made some remarks on "Ether Anæsthesia."

Dr. Howard A. Kelly, of Baltimore, Md., followed with a paper entitled "Hand Disinfection."

Dr. I. S. Stone, of Washington, D. C., read a paper on the "Pedicle in Hysterectomy."

The principal methods were described and illustrated by colored drawings, showing the arrangement of the pedicle in the abdominal wound. The author claims a revival of interest in the operation, and that there is need for its frequent performance. The statistics are far better now than ovariotomy claimed after it had become an operation of election, and was firmly planted in public favor.

Particular attention is given by the author to tying off the broad ligaments and the use of the elastic ligature. Sewing the parietal peritoneum to that of the pedicle in the extra-peritoneal cases was also dealt upon.

The method by ventro-fixation had given good results in the author's hands, and served to accomplish two important purposes, viz: A speedy convalescence, and avoids the disagreeable sloughing which follows the use of the wire clamp. It may also be used in some cases of short pedicle where the wire may not easily be applied. The methods were compared and statistics furnished, showing that the extra peritoneal method with wire and pin gave better results than either of the others. That ventro-fixation came next and the intra-peritoneal method came last, with a large m rtality. A method of closing the capsule over the stump was described, which the author claimed would answer for either *dropping* it or sewing in the wound — ventro-fixation. In the latter case the suspensory sutures are placed and the pedicle sewed in and under the lower end of the abdominal incision. Great care is required in closing the capsule over the raw surface of the stump so that separation may not occur. Owing to the peculiar contractile nature of the capsule, care must be taken to leave sufficient length for approximation of peritoneal surface.

The uterine arteries are to be tied in any case when hemorrhage is likely to occur, and drainage may be required. Besides reference to methods the author described the process through which the wound passes subsequent to supra-vaginal hysterectomy.

All myomatous tissue should be removed, which can only be effected in some cases by a process of reduction of the pedicle. This is very important, as in the operation where a large amount of myoma is left, more time is required for atrophy and absorption to reduce the pedicle to its proper size. Great danger to the patient is apt to follow, where a broad base of the tumor is left in either method of treatment, because this mass must be disposed of before the patient entirely recovers.

The author had observed a sufficient number of cases to declare that permanent fixation of the stump to the abdominal wall was the rule, where the extra abdominal methods were used, and especially when the broad ligaments were cut away to prevent traction.

SECOND DAY—AFTERNOON SESSION.

The association was called to order by the First Vice-President, Dr. J. McFadden Gaston, of Atlanta, Georgia.

The first thing in order was the Annual Address of the President, by Dr. L. S. McMurtry, of Louisville, Ky. Dr. McMurtry selected for his subject "A Plea for Progressive Surgery." He said within fifteen years the entire practice of surgery has been revolutionized. New methods have been introduced and new regions invaded; comparatively recent teachings have become obsolete in practice, and modern treatises recast. The science and art of gynæcology, which a few years since was limited to a small and narrow field, has grown into a great branch of medical science and practice. Formerly divided between midwifery and surgery, as a minor branch of one or both, gynæcology has become an independent and essential department of the healing art.

When Marion Sims announced through the columns of the British Medical Journal that he believed the proper course of treatment in every case of gunshot wound of the abdomen is to open the stomach, search for the bleeding points and secure them, and suture intestinal perforations, he was pronounced by many eminent surgeons to be a dreamer. The suggestion of Sims was most timely, and shortly afterwards Bull successfully executed the operation. For years the treatment of opium in full doses had been pursued, with death in waiting. Now there is scarcely a State in the Union that one or more patients have not been rescued from certain death by prompt resort to operative treatment. He mentioned these circumstances to illustrate and emphasize the point that surgery is advanced more by the aggressiveness of the surgeon than by timidity. In the face of desperate conditions of disease and injury, where there can be no safety whatever in delay and palliation, the only treatment worthy of consideration is the aggressive course which promises success. Under such conditions the most heroic surgery is conservative, and any other course is not conservative.

Dr. Thomas Addis Emmet, of New York, read a paper entitled "Injuries to the Pelvic Floor and the Method of Repairing the same."

Dr. Joseph Taber Johnson, of Washington, D. C., followed with a pape on "The Growth of Fibroid Tumors of the Uterus after the Menopause."

He said the object of the paper was to put on record cases and opinions in opposition to this view of this important subject, and to aid in recasting our views and in modifying our practice.

He had within the last five years seen at least a dozen women with large growing and troublesome fibroid tumors of the uterus, who were over 50 years of age; some of them over sixty. These women had been assured by their physicians that if they could get along somehow until after the change of life their tumors would not only stop growing, but that they would lessen in size, and probably go away altogether; at least, the troublesome and dangerous symptoms would disappear. They had been advised against any radical operation, and encouraged to believe that as they grew older they would get entirely well. In perhaps the majority of cases this might prove to be very good advice, but the point which the author wishes to make is, that as we are now better acquainted with the history and behavior of these tumors, this is no longer safe advice to give. We cannot assure any woman that her tumor may not prove to be one of the exceptional cases, and that it may not grow more rapidly after the menopause than it did before, or that it may not present complications equally distressing and disastrous. When from forty to fifty per cent. of women subject to supravaginal hysterectomy died from the effects of the operation, this was very safe and conservative counsel to follow. The possible dangers of the tumor were not equal to the probable dangers of the operation.

The author drew the following conclusions:

1. That the "rule" stated in the text-books that the uterine fibromata ceased to grow after the menopause, has many more exceptions than is generally supposed.

2. That when they continue to grow after the menopause they pursue a more disastrous course than before.
3. They more frequently become cystic, calcareous or have abscesses develop in them.
4. These conditions, requiring operation according to well-known rules of surgery, the patients are in a less favorable condition for recovery than before the menopause.
5. If the above conclusions are admitted to be true it must follow that they furnish additional indications for more frequent and earlier resort to the radical operation.

In the hands of the best operators in cases where a pedicle can be secured, the mortality of supra-vaginal hysterectomy is rapidly approaching that of ovariotomy.

"The Surgical Treatment of Anterior Displacements of the Uterus." Dr. C. A. L. Reed, of Cincinnati, Ohio, read a paper on this subject.

He said anterior displacements of the uterus, when they exist to the pathological degree, are the opprobria of the gynecic art. It is indeed true that many wombs lean far forward without inducing symptoms, but it is likewise true that many of them that are thus malposed do entail symptoms, objective and subjective, that frequently baffle our resources. It is a misfortune too, that many of all the displacements in which the womb is liable, those in which the organ deviates anteriorly to the normal axis are vastly the more prevalent. Thus in an aggregate of four hundred and ninety-four cases by Nonat, Meadows, Scanzoni, Valloix and Hewitt, quoted by Thomas and Munde, there were two hundred and ninety-four ante-flexions and one hundred and eighty retro-flexions; while Munde himself reports two hundred and ninety-four ante-flexions, thirty three retro-flexions, and ten latero-flexions in a total of three hundred and thirty-seven cases. As the latter authority is disposed to look upon ante-flexions in their minor stages as a physiological (even congential) condition, it is legitimate to infer that his statistics are based upon observations of displacements in the pathological degree. The conclusion is forced upon us then, that of all the displacements of the uterus, those of the anterior variety are the more frequent; while the records of practice will force us likewise to the conclusion that of all of the womb displacements those of the anterior variety are less amenable to treatment than are any of the others.

In the treatment, the term *surgical* is employed in contra-distinction to any method of treatment by pessaries, tamponnage or electricity. It may be premised that all surgical methods devised for the relief of these conditions should be directed, first, to the removal, when practicable, of the causes of the diseased conditions proper, and, finally, to the readjustment of the diseased organs to the normal physical forces of the pelvis.

In conclusion the author desired the Association to consider

1. The etiological relationship of contracture of the utero-sacral ligaments to ante-flexion.
2. The possibility of overcoming this condition by such conservative measures as rest, pelvic depletion and appropriate manipulations.
3. The feasibility of removing the obstructive dysmenorrhœa and the sterility usually incident to these cases by the plastic operation which he had described.
4. The inexpediency of forcible dilatation for the relief of these cases and its inability to effect a permanent cure.

"The Part the Shoulders play in Producing Laceration of the Perineum, with Suggestions for its Prevention." This was title of a paper read by Dr. W. D. Haggard, of Nashville, Tennessee, in which he made the following suggestions:

1. The patient should occupy the left lateral decubitus at least during the second stage of labor.
2. Overcome rigidity of the vulvar outlet by the judicious use of chloroform.
3. The presenting part of the child should be supported and not the perineum during the passage of the head and shoulders.

4. Support the head by pressing it well up under the symphysis pubis by placing the right thumb in the rectum and fingers of the right hand expanded over the occiput.

5. To retard the exit of the shoulders, pressure should be applied to the trunk and shoulder by placing the index and middle fingers of the left hand in the rectum with the thumb in the vagina to restrain its exit.

6. Support the head and neck by pressure well over the symphysis pubis.

NOVEMBER 12TH, THIRD DAY—MORNING SESSION.

The Association was called to order by the President at 10 a. m.

Dr. James A. Goggans, of Alexander City, Ala., read a paper entitled "Abdominal Section in a Case of Cyst of the Mesentery." He stated that he had been induced to write a paper on the case from the fact that cysts of the mesentery are extremely rare, and that operations for their removal are most generally fatal. He said that he had been able to find the record of one case of cyst of the mesentery removed by enucleation by Guyon. The patient died on the 7th day after the operation. One case operated upon by Sir Spencer Wells, the operator in that case incised and drained the cyst, but the patient died within a few weeks. Three cases operated upon by Pean, only one of which recovered. One case operated upon by Watts, but that he did not know the result in the case. One case operated upon by Cortes, who incised and drained the cyst, but the patient died from septicæmia and hemorrhage. One case operated upon by Bantock, who removed the cyst by enucleation and the patient recovered.

The conclusion arrived at as to the origin of the cyst in that case, both by Dr. Bantock and the pathologist who examined the specimen, was that it originated from some fœtal structure, possibly some of the rudiments of the permanent kidney. He said that Dr. Greig Smith says, that he knows of two cases of mesenteric cyst removed by operation by his friend, but that he could not relate them to him, as they had not yet been published. He said that the patient upon whom he had operated for a cyst of the mesentery was a young woman, 21 years of age, daughter of a physician of Columbus, Ga. She had not been well for two years, but did not know that her abdomen was becoming larger until three months before the operation. During those three months she had been treated for abdominal dropsy, and had suffered much uneasiness and pain in the abdomen, and at the time of the operation her pulse was 120, and the temperature 100 degrees Fahr. The cyst was quite large, occupied mostly the left side of the abdomen, extended from under the ribs into the left lumbar region, dipped downward into the pelvis and extended three or four inches beyond the median line of the abdomen into the right side. He said that he first removed about a quart of the fluid by aspiration on February 7, 1891. The fluid was thin and of a dark color, and contained albumin, phosphate and chlorides. The patient was not benefited by the operation, and the abdominal section for the removal of the cyst was made on February 24th, 1891.

The cyst was covered with omentum and mesentery, and loops of small intestines were imbedded in its walls. An attempt was made to enucleate it, but hemorrhage was so free that the idea of enucleation was soon abandoned. A point as remote as possible from blood vessels and intestines was selected, the cyst incised and drained. More than one gallon of a thin, dark-colored fluid was evacuated, the sac irrigated with hot water, the lips of the incised sac stitched to the upper angle of the abdominal incision, and a glass drainage tube introduced to the bottom of the cyst. The abdominal incision was then closed with silk worm gut sutures. The author was confident that the cyst was retro-peritoneal. The time consumed in the operation was 25 minutes. The sac was irrigated three or four times in the twenty-four hours, and the drainage tube gradually withdrawn. The patient suffered much from nausea and vomiting, which he attributed to the close connection between the walls of the sac and the loops of small intestines. The patient made a good recovery within thirty days. He presented

a picture of the patient which was taken the 1st of November, 1891, which showed her to be in perfect health.

"Thinness of Uterine Walls Simulating Extra-Uterine Pregnancy, With Report of Two Cases," was the title of a paper by Dr. Geo. J. Englemann, of St. Louis, Mo.

The author said there are many difficultics in the way of a positive diagnosis of early pregnancy, even in cases surrounded by conditions less unusual, but they assume alarming proportions when aggravated by the curious complications which may arise in individual cases, and above all when conditions are simulated in which delay is dangerous and operative interference seems called for, when a decision is urgently demanded, a decision upon which a life, and perhaps two, may depend. Whilst the auditor may criticize at his leisure and readily differentiate the conditions depicted, it is only he who is to pronounce and to act who can realize the difficulties of this entangling and so knotty a problem.

CASE 1—Patient 32 years of age, had borne three children in the six and a half years of her married life, the youngest twenty months ago, which was still nursing, and the menstrual flow has not as yet reappeared since the birth of this child. The patient came to his clinic for relief from a variety of discomforts from which she had been suffering more or less for the past three months. She complains of sick headache, vomiting spells, fullness of the stomach, belching after meals, and intermittent swelling of the abdomen, a pain in the groin appearing before such swelling, and a small tumor above the right groin, which she first noticed three weeks ago, and as she stated, "then suddenly made its appearance." An examination revealed large varicose veins over the lower limbs; a solid, round, movable tumor above symphysis and right groin; the cervix low and large; the uterine body thickened, lying low in the pelvis, with a certain mobility independent of the super-imposed tumor; an applicator entering three and a half inches slightly ante. Notwithstanding the wine color of the pronounced cystocele and the cervix, pregnancy seemed out of the question, and the tumor was diagnosed as most probably a dermoid of the right ovary, hardly one connected with the uterine wall. In the course of an examination two weeks later, a very different condition of affairs was revealed. The tumor had disappeared and a fœtus was found in the utero-vesical space, freely movable, apparently floating about, the small parts being distinctly felt as if underneath a wet towel both through the vagina and abdominal walls. So distinct did the small parts appear to the examining finger, that it seemed impossible to realize that even as much as a thickness of the vaginal tissues should intervene, and the abdominal walls must certainly have been very much attentuated to disclose the fœtal parts with such distinctness. Probe showed the uterine cavity free six and a half inches in length. still slightly ante, but never curving forward in the direction of the previous tumor.

The treatment for the supposed subinvolution was discontinued, the patient warned to keep quiet and to notify Dr. Englemann upon the occurrence of any abnormal symptoms. He believed the case to be one of ectopic gestation, either within the broad ligament or in the abdominal cavity after tubal rupture marked by the sudden appearance of the tumor five weeks ago, yet he was not sufficiently positive to warrant the immediate resort to the knife, and well that he did not do so, as persistent treatment and repeated examinations resulted in labor pains and the delivery of a five months fœtus in the most correct and natural manner.

Dr. Robert T. Morris, of New York, contributed a paper on "The Removal of Necrotic and Careous Bone with Hydrochloric Acid and Pepsin."

The author said sometimes it is desirable to remove dead bone without subjecting a weak patient to a dangerous or deforming operation. Attempts have been made with some success at clearing out this bone by a process of defalcification, but there are two chief reasons why failures have resulted as a rule. In the first place, it was discovered that superficial layers of dead bone were decalcified easily enough, but the acids did not

reach deeply through the mass, especially if portions were infiltrated with caseous or fatty debris. In the second place, cellulitis was pretty apt to develop during the course of treatment.

After much experimentation he had finally adopted a method of work which seemed to be complete. An opening is made through soft parts by the most direct route to the seat of dead bone, and if sinuses are present, they are all led into the one large sinus, if possible. The large direct sinus is kept open with antiseptic gauze and the wound is kept open with anni septic gauze and the wound allowed to remain quiet until granulations have formed. Granulation tissue contains no lymphatics, and absorption of septic material though it is so slow that we have very good protection against cellulitis. The next step consists in injecting into the sinus a two or three per cent. solution of hydrochloric acid in distilled water. If the patient is confined to bed the injections can be made at intervals of two hours during the day; bu' if it is best to keep the patient up and about, the acid solution is thrown into the sinus only at bed time. In either case the patient is to assume a position favorable for the retention of the fluid. Decalcification of exposed layers of dead bone takes place quickly, and then comes the necessity for another and very important step in the process. At intervals of about two days an acidulated pepsin solution is thrown into the sinus (he uses distilled water, oz. iv, hydrochloric acid, m. xlv; Fairchilds' pepsin, dr. ss.) and this will digest out decalcified bone and caseous and fatty debris in about two hours, leaving clean dead bone exposed for a repetition of the proceedure. The treatment is continued until the sinus closes from the bottom, showing that the dead bone is all out.

Even in distinctly tuberculous cases the sinuses will close if apparatus for immobilizing diseased parts and tonic constitutional treatment are employed, as they should be, in conjunction with our efforts at removing the dead bone. If suppuration is free in any cavity in which we are at work, it is well to make a continual practice of washing out the cavity with peroxide of hydrogen before each injection.

It is a popular impression that living bone is not attacked by dilute mineral acids, but as it makes a good deal of difference whether the impression is correct or not, he experimented as follows: A portion of the keratinoid layer was removed from the carapace of a turtle (nanemys guttatus) and the animal was then placed tail downward in a glass of five per cent. hydrochloric acid solution. In the glass he placed also a segment snipped from the plastron of the turtle, and a transverse segment from an old dry humerus of a man. The piece of humerus was completely decalcified in six hours; the segment from the plastron was soft in about twenty hours; and the carapace of living bone was decalcified at the exposed part in thirty hours. He was then curious to know what effect the acid had had upon the blood vessels of the decalcified bone, and Dr. Smith, of the laboratory section of the Post-Graduate Medical School, made for him several sections of the carapace which included both decalcified and healthy bone. Investigation showed that all of the blood vessels were destroyed wherever the bone was softened, and the action of the acid had extended farther up along the larger blood vessels than elsewhere.

The difference in time between decalcification of the dead bone—six hours, and of living bone, thirty hours, is significant; a five per cent. solution of the hydrochloric acid having been used. If we use a two or three per cent. solution of hydrochloric acid a wall of lymph and of granulation tissue is thrown out upon the surface of the living bone for protection, and only dead bone is attacked. This at least has been his observation in several cases in which the results of treatment could be easily watched.

Dr. Landon Carter Gray, of New York, in a paper entitled "The Present Status of Cerebral Surgery," touched upon the modern aspect of intra-cranial surgery. The speaker first passed in review our present knowledge of localization of functions of the brain, stating that we were well acquainted with the functions of the motor area, of the third frontal convolutions, the cuneus, certain portions of the basil ganglia, the base of the brain and the cerebellum, and that we know nothing, or had still under discussion, the

localization of the centers for the sensations of touch, pain, muscular sense, temperature sense, most of the parietal lobe and most of the temporo-asphenoidal lobe with the exception of the olfactory lobe. He stated that operations for fracture of the skull with or without hemorrhage, for abscess and for tumors that were removable and localizable, were usually successful; those for so-called idiopathic epilepsy were utterly valueless, as were also those for epilepsy supposed to be due to genital or ovarian irritations, whilst those done for epilepsy due to removable or localizable lesions of the intra-cranial contents were usually successful so far as the lesion was concerned, although it was a grave question as to whether the epileptic habit was ever cured; the latest operation for idiocy supposed to be due to premature ossification of the fontanelles was still under discussion and consideration, the cases being too few and too recent to permit of any conclusion; whilst the operation for hydrocephalus and for epilepsy due to such early infantile and fœtal lesions as parencephalus, hemorrhage and meningitis, were indefensible. He further impressed upon surgeons the great difficulty that there often was in finding a sub-cortical lesion of the centrum ovale that was deep-seated or small, and the fact should be borne in mind that there might be no decussatio of the motor fibres from the hemispheres, so that a lesion would be found upon the same side as the paralysis.

"Some Complications of Psoas Abscess." This was the title of a paper read by Dr. J. McF. Gaston, of Atlanta, Ga.

THIRD DAY—AFTERNOON SESSION.

Dr. Paul B. Barringer, of Richmond, Va., read a paper on "Venomous Serpents of the United States and the Treatment of Wounds Inflicted by Them."

Dr. Christopher Tompkins, of Richmond, Va., followed with a paper entitled "A Case of Induced Abortion for Relief of Nausea and Vomiting, with Remarks."

On August 1, 1885, he was called to see Mrs. J., aged 24, and, as nearly as could be ascertained, three and a half months pregnant with her first child. Patient was born in the mountainous part of Virginia; she had an active outdoor life and grew up to be a woman of good height and of round full figure. January 14, 1884, she was married. While in the city of New Orleans, in stepping from the platform of a car, she sprained her ankle. This, although treated immediately by a physician of that place, and subsequently in this city, caused her great suffering. Finally, refusing to yield to the usual treatment, the part was put in a plaster cast; she went about on crutches, and after many months recovered. In the meantime she became pregnant, and from the first was attacked with nausea and vomiting. Mild in the beginning, it gradually increased in gravity, till she sent for him on the 1st of August, 1885. Her husband stated that she had had fever for two weeks. He found her in bed and learned that she had been there for days; her figure not robust and her face thin and attentuated. What little she had eaten in the past ten days or two weeks had been apparently rejected, her temperature one degree above normal; tongue foul; sordes on the teeth and the breath of a sour and bilious odor. The pulse was fairly good, considering her condition. Even the mention of food was distressing to her, and the sound of the dinner bell, though far off from her, caused so much distress, that its ringing was discontinued by the family. The bowels throughout her pregnancy had been constipated, only moving once in two or three days. Although continuously retching, very little or no blood had been seen in the material vomited, except on two occasions, and then not a great deal, and such as there was, was of a florid, scarlet color. No medicine had been given, and no treatment taken except the occasional use of lime water, which she said "did no good."

The patient did not improve up to August 7th, when Dr. Tompkins, thinking the case one of the greatest gravity, and that the question of abortion could no longer be deferred, invited Drs J. B. McCaw and Aaron Jeffery to meet him in the afternoon in consultation. All agreed that

abortion must be produced, in order to give the patient a last chance for her life, which was done.

REMARKS: The case is reported principally because it was an unsuccessful one, and because he wished to disabuse the minds of those who are not experienced in such operations of the notion, commonly believed, and often expressed, that the induction of abortion for the nausea and vomiting of pregnancy is, in skillful hands, an undertaking devoid of danger and necessarily attended by success. In this case, he is of the opinion that death was the result of the protracted debility and enfeebled constitution, due to long confinement and suffering; first, from the injury to her ankle, from which she had not recovered when she became pregnant, and was attacked by nausea and vomiting, this last continuing until her death. Under such circumstances the outlook was indeed very unfavorable, for to the shock of operation and depression incident to the use of chloroform, there was added fever and protracted prostration, both from injury to the ankle and from want of nutrition, the result of the long existing nausea and vomiting. He had before and since operated on women for the nausea and vomiting of pregnancy and with success, whose apparent condition was much worse than that described in the above case, but without the history of a previous injury or disease.

The prognosis, always unfavorable, ought, when the case is so complicated, to be of the most guarded kind. The practitioner should not, however, hold his hands on this account, for the operation affords the poor sufferer the only opportunity of relief. The author uses metal dilators instead of tents, and completes the operation at one sitting. He is likewise convinced that the least possible chloroform used, the better the result.

The following officers were elected:

President—Dr. J. McFadden Gaston, Atlanta, Ga.

First Vice-President—Dr. Cornelius Kollock, Cheraw, S. C.

Second Vice-President—Dr. Geo. Ben Johnston, Richmond, Va.

Secretary—Dr. W. E. B. Davis, Birmingham, Ala.

Place of next meeting, Louisville, Ky., second Tuesday in November. 1892.

Chairman of Committee of Arrangements—Dr. L. S. McMurtry, Louisville, Ky.

GYNECOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE. NOVEMBER MEETING.

The president, Dr. William E. Moseley, in the chair.

Dr. John Morris gave an address entitled "A Parting Word Upon Obstetrics."

"I began the practice of obstetrics forty-six years ago, and for the first four years kept a record of my cases. The first year I attended thirty-five cases. I was associated with Dr. Hintze, who at that time had a very extensive general practice, and who was very often called to assist midwives in their troublesome cases. I kept a careful record of my first two hundred cases, but after that I abandoned the record, a fact which I have since very much regretted.

"My first case was a very unfortunate one. I attended the patient in my student days. This woman was in the country, and was in labor three days. At the end of that time I sent for Dr. Hintze, who delivered her with the crochet. On account of the long impaction of the head, the whole of the anterior wall of the vagina sloughed away. The woman is still living, but so much tissue was destroyed that it was quite impossible to close up the opening, and all these years the urine has been passing from her as rapidly as secreted.

"My second case was a black woman who had a prolonged labor. I had

never seen the forceps used, but tried to put them on and failed. After a while the child was born without any artificial assistance.

"One of my great difficulties in my first cases was to find the cervix. I had never had any practical instruction in obstetrics, and did not know that in the first stage before much dilatation that the os is usually found far back against the sacrum. Among other things that I think I have learned, is how to shorten labor. One of the best means of accomplishing this is by external pressure. I learned that from my master, Dr. Hintze. Another was to pass the cervix around the occiput; and I found that these two shortened labor very considerably. I think I acquired the art of preserving the perineum. I believe in keeping the head under control and not allowing it to be delivered too rapidly. In Ireland I learned how to preserve the perineum when using forceps. The secret is simply to change the axis of traction as the head comes to the perineum first upwards, perpendicular to the bed, and then carrying the handles far over on to the abdomen of the mother.

"I have found that midwifery is underrated in the profession; but I am convinced that in no branch is there greater opportunity to display skill and judgment. This branch is esteemed much more highly now than formerly.

"Formerly in conditions of rigid cervix it was the practice to bleed. I have done it many times, but it would not be tolerated now.

"I am convinced that hot water injections will assist in relaxation.

"I have no faith in belladonna.

"I have been fortunate in not seeing any cases of hemorrhage. I believe external pressure used during labor will prevent post partum hemorrhage. For the first ten years I used ergot in nearly every case during the second stage; but have not used it now for fifteen years. In cases of delayed labor I now prefer the forceps to ergot.

"The crochet has gone out of use, but formerly it was used frequently. Often the woman was injured and not infrequently the doctor's fingers suffered. Dr. Hintze had a glove to protect his fingers.

"We had at that time no chloroform, and often in transverse positions the woman would die undelivered because it was not possible to turn and deliver. I have not habitually used anæsthetics except in forceps cases. I have thought that they prolonged the labor but I always use chloroform when any force is to be resorted to.

"I have never used the binder because I could never see the philosophy of it. It will not stay in position and it is absurd to think it controls hemorrhage. The only good that I could ever see that it accomplished was to please the woman.

WHEN TO USE FORCEPS.

"Always use forceps when labor is delayed in the second stage. The old forceps were a much weaker instrument than the ones constructed on the Tarnier principle. I think the Tarnier forceps the greatest advance in obstretrics in my time.

"In placenta previa and in abortion we formerly used a tampon made of a handkerchief, rags, cotton or anything that could be had. These tampons were dirty and dangerous. Later I have used only the colprurynulur. It assists to dilate the os as well as being the most efficient tampon. It is clean and harmless.

"Opium is the best thing to relieve pain in labor. It does not arrest labor. When the os is dilated it increases the contractions.

Dr. F. E. Chatard exhibited at the society the obstetrical instruments used by his grand-father 1810—1840, and also those used by his father 1835—1875. He stated that he had used external pressure with apparent good effect.

Dr. Wilmer Brinton stated that external pressure was used by primitive people. He thought that in rigid os he had gotten good results from the administration of chloral in fifteen grain doses every fifteen minutes until three doses were given, as recommended by Playfair. But the number of cases in which he had given chloral was small.

Dr. G. Lane Taneyhill had used chloral per anum with great satisfaction in three cases. In less than an hour the os had been considerably dilated, and delivery was effected in each case in three hours, other remedies having failed. He had learned this treatment from our learned fellow-member, Dr. Williams—he uses 30 grs. chloral in milk.

Dr. P. C. Williams thought it was very important to consider agents to relax the parts. Chloral in 40 to 60 grain doses per anum had given good results, but sometimes it, as well as chloroform, fails to completely relax the cervix.

In his earlier experience he had encountered many cases of post partum hemorrhage, but since he had made use of a practice that is condemned by most obstetricians, that of giving ergot before chloroform, he had not had a single case of hemorrhage. He had seen no harm result from the practice but thought he had in this way shortend the labor. The objection to morphine to relieve pain is that it nauseates badly afterwards. Chloral must be pushed to get good effects. The objection to it is that sometimes it leaves the patient more or less delirious, and may seriously depress the heart if given too frequently.

Dr. William S. Gardner had used chloral in fifteen grain doses repeated every fifteen minutes in a series of cases, and found that while the patients had very little relief from pain, that a large percentage of them would be made sick at the stomach, and the discomfort caused by the disagreeable taste of the drug and by the vomiting following its use, more than counterbalanced the little good it did, and its use in this way was abandoned.

He gives it frequently for the relief of false labor pains: A dose of 30 grs. will almost invariably relieve the pains and put the woman to sleep.

Dr. Wm. P. Chunn had used chloral a number of times but could get no positive evidence of its value, but it does not seem to obtund the pain. If opium will do this it might be advisable to use it.

Dr. L. E. Neale was surprised that a discussion as to the value of chloral should be brought up. He thought that the time for discussion of that subject had passed. Whether it would act more efficiently by the rectum or by the stomach he did not know, but he thought 60 grains too large a dose and would be afraid to use that much as an ordinary dose by the mouth. The remarks were entirely too general to admit of special discussion.

WILLIAM S GARDNER, Secretary.

712 N. Howard St.

DEATH OF DR. HENRY CAMPBELL.

"AUGUSTA, GA., December 15.

"Dr. Henry Frazer Campbell died at 10:30 o'clock tonight after a long illness which commenced last February. He was unconscious the last thirty-six hours and passed off quietly. Dr. Campbell was a leading physician of Augusta, a most eminent and skilled doctor with a world-wide reputation. He was known in Europe as well as in America. Dr. Campbell was born in Savannah, Ga., February 10, 1824, sixty-seven years ago.

"He was the discoverer of the over-excito motory system, although Drs. Marshall, Hall, and Claude Benton, of London, at first disputed Dr. Campbell's claim of this discovery, but finally admitted Dr. Campbell made the discovery two years previous to them. Dr. Campbell was honorary fellow to the Imperial Academy of Medicine at St. Petersburg, Russia, a member of the American and Southern Gynecological Society, and in 1885 was honored and held the office of president of the American Medical Association. Dr. Campbell was one of Augusta's most prominent and respected citizens and his death will be deeply mourned. He leaves a wife and an only child, Mrs. Carrie Doughty. He was known by every doctor in this country and was connected with every medical association."

It is with sadness and sorrow that we transfer the above notice to our columns. The above sketch is but an imperfect portraiture of the career of a brilliant genius in medicine and surgery—a man who drank deep at all the fountains of our professional learning.

Science had no more devoted son, and bestowed upon him all her choicest laurels. He won honors in all the highest courts of earth where our noble and exalted profession had attained to highest renown.

Yes!—his honors were world wide; and his fame must live brightly forever in the hearts and minds of all those who worship at the shrine of our exalted profession. But a brighter and lovlier page ever illuminated the charming book of his long and illustrious life.

It glowed with the sunshine of a noble and tender disposition, a warm and genial heart, which reached out and included all his fellow men and especially all those who came within the range of his grand life work. His disposition was genial and bright, his friendship warm and tender, and his heart was gold with sweet tenderness like that of a woman's. While the whole profession will mourn him, none will do so with more heartfelt grief than those who felt the tender touch of his bracing hand, while young and inexperienced in the profession, as did the writer. There was a charm and grace about his deportment towards students and younger members of his profession, that those who witnessed it can never forget.

Yes!—He was an honor to his profession; he was an honor to humanity and to his native State. He was an humble trusting Christian, and a royal gentleman at all times and under all circumstances.

I love to recall his kindness to me, but I cannot speak of it wtihout being overcome by my feelings of grateful recognition; and here I roll down the curtain, dropping a tear to his memory, but shall love to recall all his kindness to me, and his great nobility of soul through all the years that God may allot me on this earth.

We extend our heartfelt sympathies to his noble wife and daughter in their sad affliction.

D. H. H.

Editorial.

CHRISTMAS has died and been buried, and from out the sepulcher the New Year comes forth smiling and happy, and full of gracious promises, and to all our readers and friends we extend our best wishes for their continued happiness and prosperity, and the wish that each returning New Year break like a radiant ray of sunlight into your lives, making for each of you a year, each page of which is illuminated with characters of love and enjoyment and wishes fulfilled.

SOME changes occur in our editorial staff with the New Year, Drs. Stockton and Nicolson retiring. The former returns to his old home, Newark, N. J., to resume the practice of his specialty with his preceptor.

The SOUTHERN MEDICAL RECORD also changes its cover, and with the hearty co-operation of our friends, we hope to improve the excellent standard this journal has already established, and by their hearty co-operation, we do not mean your subscription alone, but your contributions to the literary department as well.

THERE are no class of practitioners better able to report interesting cases and experiences than the country doctor. Isolated as they so frequently are, miles from consultation or assistance where all classes of work come under their observation and treatment, they are necessarily self-reliant, depending as they have to do on their own wit and shrewdness for diagnosis and treatment, and their ingenuity to improvise and supply the place of apparatus that may be necessary in special cases. And it is a very rare occurrence when they are not able to meet successfully all emergencies.

THERE is only one thing that these men are laggards about, only one complaint that we make against them, and it is that they will not write out and report their cases. Whenever you meet them, they tell you of any number of interesting cases and experiences; even promise to write them out for you, but that is the last ever heard of the case.

The amount of material piled away in their brains that would prove of infinite value if contributd to the literature of medicine and surgery is astonishing, for in nearly every radical change in either branch they have been the pioneers, and they have been to the profession what the pioneer has always been—the advance guard of civilization.

WE ASK these men to send us contributions of these cases and experiences. They not only owe it to themselves but to the profession. How often it occurs to a physician to see an idea published to the world, a thought which long before he had dismissed from his notice, as without value because it was his. Abide by and publish your impressions and convictions, or else tomorrow a stranger will say with masterly good grace what you have thought all the time, and you will have to receive with shame your own opinion from another. Have the courage of your convictions to publish and promulgate them, to take up the gauntlet in their defense—develop an idea with the patience exhibited by Marion Sims, who operated over thirty times on his patient before he met with complete success. The anticipations of yesterday defeated by the realizations of today; but each time recognizing and correcting an error, standing by his conviction, though his professional friends refused any longer to assist him. He remembered that time does not preserve that which has cost no time to create. How time has vindicated him and what a monument suffering womanhood should erect to his memory!

IT IS more than passing strange the mistakes made by prominent medical men as to whom honors are due for valuable discoveries contributed to medicine. For instance, a physician told me he heard Mr. Lawson Tait make the assertion in a medical address, delivered to a British Association, that the greatest achievement, the greatest progress in surgery was the discovery of anæsthesia by Dr. James Y. Simpson. Why, any first course student should know better; we advise him to study the literature of the subject. His inves-

tigation will show him that anæsthesia was first used in England by Mr. Robinson, a London dentist, on December 19, 1846, and a hospital patient was operated on under anæsthesia by the celebrated surgeon, Mr. Liston, on December 21st, the same year Dr. James Y. Simpson first used it to relieve the pains of child-birth on Jan. 19, 1847—just a month after its first use in England.

WE are glad to welcome to our midst Dr. W. E. B. Davis, who moves from Birmingham, Ala., to become associated with Dr. J. B. S. Holmes, of Rome, Ga. Dr. Davis is President of the Tri-State Medical Association, and as Secretary of the Southern Surgical and Gynæcological Association, he has contributed more to its success than any one. The Doctor has contributed some valuable papers to the literature of gynæcology and abdominal surgery, and will prove himself a valuable accession to the profession of this State. W. F. W.

THE EAST TENNESSEE, VA. & GA. TARIFF.

The November issue of the RECORD contained an editorial upon the subject of the tariff charges that have been adopted by many railroads, and in comparing them found it necessary to criticise especially that of the East Tennessee, Virginia and Georgia, as being much lower than any other of the roads doing business in Atlanta.

A communication has been received from Dr. W. C. Jarnagin, the representative of this company in the city, in which he claims that an injustice has been done him by the article in question. He states that before accepting the position the tariff was modified by the Chief Surgeon, and that he is not called to comply strictly with its demands, which of course frees him from anything personal in the criticism, as it was only directed against the official tariff promulgated by the railroad.

We take pleasure in publishing the statement of Dr. Jarnagin, and in assuring him that the article was not of a personal nature, but we do not wish to be understood as in any way withdrawing anything that applies to the company's schedule as placed upon the surgeons at other points.

ANNOUNCEMENT.

With this issue we make a change in our editorial staff, Dr. Wm. Perrin Nicolson and Dr. F. O. Stockton retiring, and the places which have been so ably filled by them will in future be supplied by Dr. J. McFadden Gaston and Dr. Willis F. Westmoreland.

To the profession Dr. Gaston needs no introduction. As Professor of the Practice and Principles of Surgery in the Southern Medical College, as a contributor to Wood's Reference Hand-Book, as one of the editorial staff of the Annual of the Universal Medical Sciences and as a contributor to the International Clinic, he has made for himself a national fame. He comes to us bringing with him a rich store of knowledge which he has acquired through long years of the practice of his branch, both in this and other countries. He is also Chairman of the Section of Surgery of the American Medical Association and President of the Southern Surgical and Gynæcological Association.

The mere name of Westmoreland is too well known in medical circles, both North and South, to need mention here. Dr. Westmoreland is the brilliant young Professor of Surgery in the Atlanta Medical College, is a gentleman of high scholastic attainments, and is a bright luminary among the foremost medical writers of the day.

We are determined during the year 1892 to get out a journal that will, both for selection of matter published and artistic typographical design, take a high stand among the very few really excellent ones which are now published—one especially adapted to the active practitioner, and which will give him in a concise manner all the leading and valuable medical news of this progressive age.

It was our intention to change our cover with this issue, but being unable to get paper cannot do so till our next.

MEMBERSHIP in the American Pharmaceutical Association is obtained only by election at the annual meeting. "Every pharmacist and druggist of good moral and professional standing, whether in business on his own account, retired

from business, or employed by another, and those teachers of pharmacy, chemistry and botany who may be especially interested in pharmacy and materia medica" are eligible for membership. For blank application and further information, address Dr. H. M. Whelpley, 2729 Washington Avenue, St. Louis, Mo., Chairman of the Committee on membership.

TREATMENT OF INFANTILE PARALYSIS.

Dr. Simon, the renowned Paris specialist in children's diseases, recommends the following treatment for infantile paralysis: At first counter-irritation along the vertebral column at the points corresponding to the roots of the paralyzed nerves. At the same time stimulate the functions of the skin by warm baths or vapor baths, given to the child in bed.

Chloral, aconite and conium are used to calm the nervous excitement.

After the first week electricity should form the basis of the treatment. Weak galvanic currents should be used, the negative pole being placed in a basin of water, into which the hand is plunged, while the positive pole is applied labile to the arm and shoulder. Length of treatment eight to ten minutes.

Later, faradism is to be used, but always with the greatest prudence.—W. F. R.—*Journal Nervous and Mental Diseases.*

BOOK REVIEWS.

SYLLABUS OF OBSTETRICAL LECTURES.—By Richard C. Norris, A. M., M. D., Demonstrator of Obstetrics University of Pennsylvania, Physician to the Methodist Episcopal Hospital. Published by W. B. Saunders, Philadelphia, Pa.

A second edition being published as soon as sufficient evidence that such works are in demand.

While such compends should not take the place of text books, yet there is much in this work to commend.

It is brief, concise, tersely written, and contains many points of interest for the general practitioner as well as student.

It is rare to find so many good things in so small a work.

The blank leaves add to its usefulness for inserting individual opinions.

As a compend it will certainly prove useful.

R. R. K.

THE MEDICAL REVIEW VISITING LIST PERPETUAL.—Published by J. H. Chambers & Co., St. Louis, Mo. Price 75.

It contains 24 pages of text with 37 pages of blanks usually found in such books.

In the text may be found: Artificial Respiration, Care of Galvanic Batteries, Disinfectants, Examination of Urine, Poisons and Antidotes, Tables of Doses, Doses of Medicine for Children, Table of Equivalents, Comparison of Thermo-metric Scales, Metric System of Weights and Measures, Diet Tables for Diabetics, Diagnostic Table of Euptive Fevers.

Being perpetual, price so low renders it a cheap, useful Visiting List.

K.

THE MEDICAL NEWS VISITING LIST FOR 1892.—Published in four styles, by Lea Brothers & Company, Philadelphia Pa.

Weekly, dated for 30 patients, monthly, undated, for 120 patients per month; Perpetual undated, for 30 patients per week, per year, and perpetual undated, for 60 patients per week, per year (without text.) The first three styles contain, 2 pages of text and 176 pages of blanks. The 60 patients

style consists of 256 pages of blanks. Wallet size, flexible leather cover, pocket, pencil and catheter scale. Price, any style, $1.25. Thumb lettered index, 25 cents extra.

This is a very neat, compact, useful visiting list, containing in text: Signs of Dentition, To find Day of Confinement, Thermo-metric Scales, Weights and Measures (ordinary and metric), Comparative Scales, Examination of Urine, Incompatibles, Artificial Respiration, Table of Eruptive Fevers, Poisons and Antidotes, Table of Doses, Therapeutic Remedies, Ligations of Arteries, with the blanks necessary for the use of a busy practitioner. K.

BLAKISTON'S VISITING LIST for 1892 is an elegant, compact, convenient, useful companion.

It contains:—

Hall's Method in Asphyxia, Poisons and Antidotes, Metric System, Dose Table, New Remedies, Aids to Diagnosis and Treatment of Diseases of the Eye, Diagram of Eruption of Milk Teeth, Posological tables, Disinfectants, Examination of Urine, Incompatibility, Table to Calculate Period of Utero-Gestation, Sylvester's Method of Artificial Respiration, Transportation of Injured Persons and Diagram of Chest.

It also contains the blanks usually found in first-class visiting lists.

It is issued in Regular Edition, Inter-Leaved Edition. Perpetual Edition same a Regular Edition without dates.

Published by Blakiston, Son & Co., Philadelphia. Sent on receipt of price.

THE COLUMBIA DAILY CALENDAR.

An old friend in a new dress, and an article that has come to be one of the indispensables of an editor's desk, comes to hand in the Columbia Daily Calendar for 1892. The Calend r is in the form of a pad containing 367 leaves, each 5⅛x 2⅝ inches; and each slip bears a short paragraph pertaining to cycling or some kindred subject, and at the bottom of each leaf is a blank for memnranda. The stand is an entirely new departure, being made of sheet metal finished in ivory black, and is very compact. This is the seventh issue of this now well-known Calendar, yet all the matter is fresh and new.

Selections and Abstracts

THE TREATMENT OF SYPHILIS.

Hefte 8 u. 9. 1891, of the *Wiener Klinik* contain the valuable work of Dr. Elsenberg on the treatment of syphilis. After discussing the curability of this disease, the question of re-infection, the results of the excision of the primary lesion, he comes to a consideration of the means at our disposal for the successful treatment. For the primary lesion, if phagedenic, the ordinary antiseptics are recommended: corrosive sublimate, carbolic acid, iodoform, derivaties of iodine. He recommends the method of inunction as the best of all for external use of mercury. He insists that a full warm bath which contains a pound of soda, the patient being well rubbed with soap, shall be taken for two or three days before treatment; that the teeth shall be put in order, and any inflammation of the mucous membrane of the mouth shall be treated by washes of 5 per cent. solution of salol dissolved in alcohol and well diluted with water. For inunction he advises the ordinary blue ointment popularized by Lebeuf, in doses from one-half to one and a half drachms. The time required for thorough inunction of the minimum quantity is upward of half an hour. This treatment is to be continued until all symptoms have disappeared, or eight or ten more treatments have been made, or there intervenes swelling of the oral mucous membrane. For six or eight weeks succeeding this treatment the iodide of soda or potash is to be employed. Although placing his reliance upon the inunction method, yet the author gives a very complete history of the various mercurials used for internal medication, as well as those used hypodermatically, both the soluble and insoluble salts.

In the administration of the iodides he prefers the iodide of potash, in doses sufficient to accomplish his purpose, even to one hundred and fifty grains *per diem.* The iodide of soda is to be substituted when potash is contra-indicated, because of the condition of the heart. In rare cases iodoform or odol (thirty to forty-five grains *per diem*) may be substituted.

[Although but little that is new is to be found in this monograph, yet the litrature has been so thoroughly studied, the

opinions of the clinicians discussed with so much fairness, the indications for treatment so clearly given, the methods to be employed so accurately described, that the careful perusal of this work will amply repay one who wishes to keep himself fully informed on the subject.—ED.]—*Amer. Jour. Med. Sciences.*

SPECIFIC ABORTIVE TREATMENT OF PNEUMONIA.

Francisco Moliner (*El Singlo Medico*, Madrid, October 18, 1891,) in an address before the Medical Congress of Valencia, insists that a specific abortive treatment of pneumonia is rational and possible. The idea of a morbific germ carries with it the idea of a specific remedy. Anything that will retard or cut short the evolution of the micro-organism will retard or cut short the clinical evolution of the disease. It is not necessary to kill the germ, but only to modify, in some degree, its virulence. Nor is it necessary that the remedy act on the microbe itself; it is enough if it act on the organism, increasing its resisting power, combating predisposition, or neutralizing the poisons generated. The rapidity of the development of the pneumococcus, indicates the necessity that the treatment should be begun early. One of the first pathological effects manifested in pneumonia is the alveolar congestion. This is caused by a ptomaine generated by the microbe which paralyzes the vaso-motors, and this congestion aids the further development of the micro-organism. Cold, acid media, well-oxygenated air and antiseptics, all retard their evolution. Hence the following plan of treatment is suggested: (1) The continued application of ice to the chest-walls, with inspiration of cold air. This hinders directly the growth of the germs, reduces the temperature, and combats the primary congestion. Lees gives statistics of sixteen cases treated in this way, with favorable results. (2) Inhalation of cold, oxygenated air impregnated with essential balsams. (3) Inhalations of sprays of acetic or lactic acids, of vapor of hydrofluoric acid, and rectal injections of hydro-sulphuric acid gas. At the same time give moderate doses of alcohol, which, acted on by the inhaled oxygen, liberates acetic acid in the blood. This treatment, to be effective, must be applied during the first forty-eight honrs after the initial chill, before the process has become generalized.—*University Medical Magazine.*

THE ANAL REFLEX.

Rossolimo says this reflex consists in a contraction of the anal sphincters in a response to a stimulation to the skin and mucous membrane of the anus. It is invariably present in man in health. The branches of the inferior hemorrhoidal, pudendal and perineal nerves, on which this reflex depends, are connected with the third and fourth roots of the sacral plexus, which spring from nerve cells in the conus medullaris. This reflex can be obtained in the dog as well as in man, and Rossolimo cut the spinal cord across at different levels from above downwards; whenever the lumbar enlargement was cut across at the level of entry of the third sacral nerve, the anal reflex suddenly disappeared, from which it follows that the cells of the spinal cord which are connected with this reflex are situated in the third quarter of the lumbar enlargement, reckoning from above downwards. In another series of experiments the lumbar enlargement was exposed and the sacral roots were cut one at a time. By this means it was proved that the anal reflex depended upon the integrity of the third and fourth sacral roots. This reflex, therefore, has its seat in the cord lower than any other reflexes. To obtain the anal reflex the patient may be either standing, the operator separating the glutei, or lying on his side, with the legs drawn up. The skin and mucous membrane of the anus may be stimulated by stroking with a pin, a feather, a piece of paper or some suitable object. The reflex is shown by a contraction of the sphincter and ani externus and if it is very strong there is a drawing in of the whole anus and even sometimes a contraction of the glutei. In women the testing of this reflex may be conveniently combined with a gynæcological examination. The author has examined this reflex in a great many conditions and he comes to the following conclusions: It is increased in some cases of neurasthenia, in cases of myelitis high up in the cord, and in conditions in which there is a general exaltation of sensations. It is lost in multiple neuritis affecting the sacral plexus, in some cases of tabes and in myelitis of the lower part of the cord and in these cases there

is generally also anæsthesia of the rectum, anus and urethra. It remains normal in functional derangements of the bladder, the rectum and the sexual apparrtus.—*Boston Med. and Surg. Jour.—Alienist and Neurologist.*

TREATMENT OF INFLUENZA WITH CAMPHOR.

During the recent epidemic, when I had on an average of 150 cases a week under my care, I had ample opportunity of testing the efficacy of various methods of treatment. My fisst idea was to try to alleviate the most prominent symptoms—namely, backache and general pains, with sod. salicyl; headache, etc., with analgesin, combining either of the above with a sedative or stimulating expectorant if the chest was affected. I also used ergot and digitalis in combination in a few cases, believing the disease to be simptly due to a vaso-motor chɛnge, but I afterward came to regard it as a zymotic disease, with probably a special bacillus of its own. Amongst other drugs I tried camphor, and with so much success that I rarelv prescribed anything else afterward, six doses or less usuɔlly being sufficient. I administered it as follows :

℞ Sp. Camph.,	-	dr. ij.
Tinct. lavand co.	-	dr. ij.
Sp. chlorof.	-	dr. j.
Mucilag. tragacanth		oz. ij.
Aq. ad.	-	oz. vj.

Oz. j quartis horis sumend.

This cost very little, and, by leaving out the flavoring agents the effect is the same and the cost nominal.—*Long, British Medical Journal.—St. Louis Clinique.*

TREPHINING IN A CASE OF GENERAL PARALYSIS.

M. Key reported a case in which he thought the disease was benefited by the intervention of the surgeon. The dura mater presented no unusual appearance. Beneath the meninges the large vessels presented a gelatinous aspect and showed milk-like plates. The brain formed a hernia which filled up the opening in the skull. A rapid examination was made.

The incisions in the dura mater were there reunited by sutures, as were also the rents in the pericranium.

The operation, which lasted an hour, was performed under strict antiseptic precautions. On awakening, the patient was quiet and contented. Eight days later, the cicatrization of wound was completed and the patient returned to ward. A month and a half later he returned to his family, the states of depression and exaltation having disappeared.

M.'Key remarks that cases of this kind may be benefited by the surgeon, even though there is no tumor or irritation of the brain, just as cases of symptomatic or essential epilepsy may be benefited. The incurability of general paresis and the recognized futility of internal treatment Justify this operation.—*Le Progres Medical*, August 15, 1891.

GONORRHŒA OF THE MUCOUS MEMBRANE OF THE MOUTH IN THE NEWBORN.

Five cases of gonorrhœal infection of the mouth in infants are reported by Rosinski in the *Zeitschrift fnr Geburtshulfe und Gynakologie*, Band xxii., Heft 1, 1891. In most of the cases the maternal source of infection was clearly demonstrated. The lesion was an infiltration of the tissues upon the tongue and hard palate, with a characteristic yellowish mass composed of gonococci and pus-cells. The general health of the children was not especially disturbed, and very little pain or distress was observed. In some instances, gonorrhœal opthalmia was also present. The children recovered under appropriate treatment. Those who had opthalmia were sickest, and suffered considerably.—*Amer. Jour. Med. Sciences.*

GUNPOWDER STAINS.

These may be removed by painting with biniodide of ammonium, distilled water, equal parts; then with dilute hydrochloric acid, to reach the tissues more deeply affected.—*Review de Therapeut.*

ACUTE RHEUMATISM CONFINED TO THE TEMPORO-MAXILLARY JOINT.

The British Medical Journal of Dental Science reproduces a report by Dr. Gallipe, published in Le Progres Dentaire, of a case of acute rheumatism confined to the temporo-maxillary joint. It occurred in a patient of rheumatic diathesis. The symptoms were swelling of the cheek on the right side; with redness and pain on pressure; mastication and talking were both painful, with exacerbations at times. Pressure over the temporo maxillary joint caused sharp pain. The upper and lower wisdom-teeth on the same side felt as if raised in their sockets. There had been no tooth-ache. Careful examination of these teeth revealed no decay. The diagnosis was made of an attack of acute rheumatism in the right temporo-maxillary joint, and the patient was put upon salicylate of soda and quinine, rapid recovery resulting. Dr. Gallipe considers that the feeling of raising in the teeth was due to an attack of rheumatism in the alveolodental membrane itself, or rheumatic periodentitis, rather than simply the extension of pain from the affected joint.—*The Lancet—Nashville Jonr. Med. and Surg.*

PAPOID IN DIPHTHERIA.

R Papoid, gr. x.
Aquæ, oz. ss.
M. F. solution.

Kohts and Asch painted diphtheretic membranes with this solution every fifteen or twenty minutes with a soft brush. They found that the oftener the application was made the more rapidly membranes disappeared. Koets treated several hundred cases by this method with the greatest success.

R Papoid, dr. ij.
Beta-naphthol, gr. iij.
Acid hydrochl. dil., gtt. xv.
Aq. destil. ad., ox. iv.

M. ft. solution. Sig. Use carefully and thoroughly by means of hand anatomizer every half hour on throat and through nostrils on posterior nares and pharynx, if deposit extends to these localities. Papoid solutions should be made fresh daily.—Ex.

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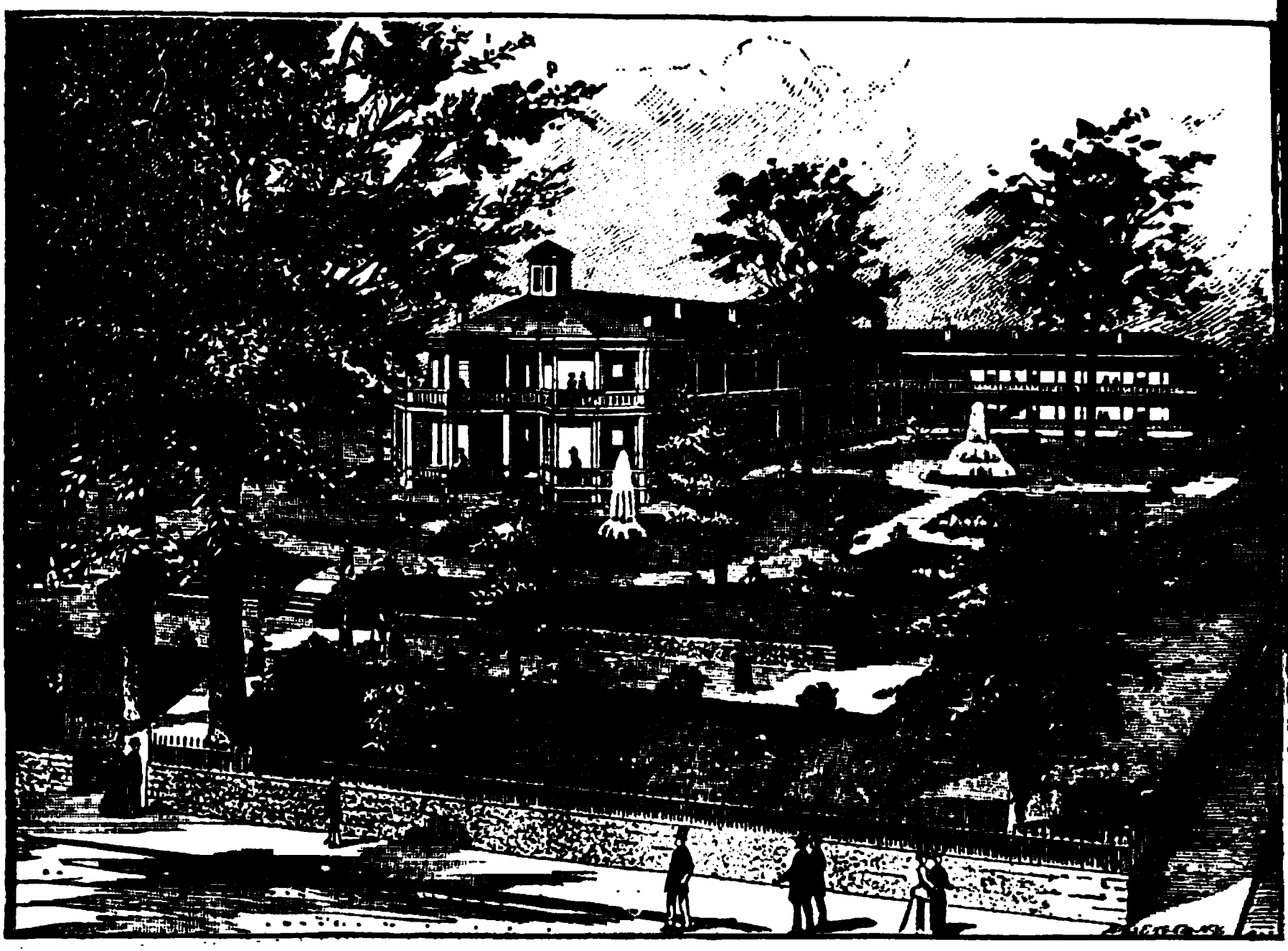

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Potassi chlorat dr. i.
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Syr. simplex f. oz. ii.
Aquæ q. s. ft. f. oz. iv.

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Quinine is the best germ destroyer we have for the microbe of influenza. During the recent epidemic I aborted quite a number of cases with antikamnia in combination with salol and quinine. The relief obtained by the administration of antikamnia where the cephalalgia was severe as in the majority of my cases, was wonderful. When the pain seemed almost intolerable, I have seen a ten grain dose of antikamnia banish it. The combination spoken of was as follows:

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M. ft. capsules No. XXX.

Sig. One every two hours.

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R. Antikamnia dr. i.
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R. Hydrarg. chlo. mite gr. i.
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Lactopeptine - dr. ss.
M. ft. Charts No. x.

Sig. One every hour until all are taken. This to be followed by a full dose of hunyadi janus or rubinat condal water.—*Med. World.*

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Alcohol, dr. iss.
Syrup of red raspberry, oz. iij

M. Dose, from a teaspoonful to a dessertspoonful every morning, according to the obstinacy of the constipation.—*L'Union Medicale.*

BILIOUS HEADACHE.—

R. Pulv. opii,
Pulv. ipecac, aa gr. 1-8th
Mass. hydrarg. gr. ss.

M. ft. tab. trit. No. i.—*N. Y. Med. Journal.*

NOCTURNAL EMISSIONS.—

R. Ext. aloes, gr. iij.
Ext. belladonna. gr. ij.
Ext hyoscyami, gr. iv.
Pulv. camphoræ gr. xxiv.

M. ft. pilulæ No. xii. Sig., one pill every night.—*Ex.*

POISON OAK ERUPTION.—

R. Ex. Goulards' oz. ij.
Oil olivæ, oz. j.

M. External use in poison oak eruption followed by benz. zinc ointment.

AN INJECTION FOR GONORRHŒA.—Prof. Keen gave the following formula to be used as an injection in gonorrhœa:

R. Zinci sulphat., gr. xviij.
Catechu,
Matico, aa f. dr. iss.
Glycerini,
Aquæ, aa q. s. ad. f. oz. vj.

M. Sig. Inject f. oz. ss., retaining each injection for at least five minutes. —*Times and Register.*

TONIC AND LAXATIVE.—

R. Aloes pulvis, dr. j.
Ferri. sub. carb., dr. ss.
Ex. Hyoscyama, dr. ss.
Ex. belladonna, gr. v.
Ex. nux vomica, gr. viij.

M. ft. mass. div. pill vel. caps. No. 30. Sig. One, a. m. and p. m.—*Ex.*

CARDIAC DEBILITY.—

R. Ferri tartarat., gr. v.
Pot. bicarb., gr. v.
Tr. digitalis, m x.
Infus. calumbæ, oz. j.

M. Sig. To be taken three times a day.

THE

Southern Medical Record.

A MONHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. XXII. ATLANTA, GA., FEBRUARY, 1892. No. 2

Original Articles.

*BROMIDE OF ETHYL, AS AN ANÆSTHETIC.

BY E. H. KUYKENDALL, M. D., CHATTANOOGA, TENN.

"The term anæsthetic, proposed by Dr. Oliver Wendell Holmes, means an agent capable of producing anæsthesia, or insensibility to pain."

It is true, anæsthesia is a term which, according to its etymological signification, should be applied to loss of sensation of touch, chiefly; and analgesia should be used to signify loss of sense of pain; however, the word anæsthesia, as expressive of the state of profound unconsciousness induced by anæsthetics, is now so firmly established by usage that it were better to retain it.

Insensibility to pain (analgesia) may be produced without simultaneous loss of common sensation, touch, as in the use of cocaine and carbolic acid.

Having administered Ethyl Bromide something over two-hundred and fifty times, and found it so extremely serviceable in the class of operations for which I make use of it, I bring this subject to the attention of this Association with the hope of doing something towards giving this valuable anæsthetic

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the place it should hold in our daily practice, alongside the other indispensable ones, chloroform and ether.

Ethyl Bromide, or Hydrobromic Ether, is a colorless liquid, volatile, having a fragrant odor and a hot, somewhat sweetish taste, afterward rather bitter. It is not inflammable. Its specific gravity is 1.420, and it boils at 104 Fahrenheit; readily decomposes on exposure to light and air, bromine being separated. It is freely soluble in alcohol and ether, but very sparingly in water.

As an anæsthetic, it was first known to Mr. Nunnely, of Leeds, and he first employed it in surgical practice in 1865.

Dr. Turnbull gave an account of its properties, based on experimental and clinical evidence, in 1877. But the most extended trials of its anæsthetic powers were made by Dr. Levis, of Philadelphia, in 1879–80. In the latter year two unsuccessful cases occurred, one in the hands of Dr. Levis, its chief promoter, and the other in the practice of Dr. Marion Sims, of New York.

These fatal cases, and some crude physiological experiments undertaken to prove that ethyl bromide is a heart paralyzer, started a reaction against this anæsthetic, then beginning a promising career, and in a short time it fell very much out of use.

I have found it, however, to have valuable properties, which should preserve it from neglect, and bring it into more constant use.

In the fatal cases recorded, there are strong doubts in regard to the share of ethyl bromide in the results. In Dr. Levis' case, the patient was far advanced in pulmonary disease, and was unfit for the administration of any anæsthetic.

In Dr. Sims' case, the death of the patient occurred a number of hours after the operation, which was a long and tedious one, requiring very protracted use of the anæsthetic. To induce complete insensibility about zj must be administered rapidly. The odor is not unpleasant, and but little irritation of the air passages is produced.

If administered in full quantity, there is a very brief stage of excitement, hardly perceptible, and the stage of rigidity is

very short and not pronounced. There is, practically, no irritation of the fauces.

The face is flushed, the ears are red, the eyes injected and watery from the increased lachrymation; the pupils more or less dilated. The action of the heart is accelerated and the pulse increases in force. The respiration is somewhat quickened. When the vapor of ether or chloroform is inhaled sense of faucial irritation and the need of air is experienced, also, more or less cough is produced.

The irritation of the fauces excites the flow of mucous, and the reflex act of swallowing. The first effect is a general exhileration; the pulse increases in frequency, the respiration becomes more rapid, and sometimes assumes a sobbing or convulsive character; the face flushes, talking, laughing, crying, singing, and sometimes praying indicate the cerebral intoxication.

This state of excitement varies in different individuals, and is more pronounced in character, and more persistent in the robust and rough natured male and the hysterical. At this period, although the patient can be easily aroused, sensibility to pain is decidedly diminished, although the sense of touch may be preserved, taste and smell are abolished and the sight is either abnormally acute, or is perverted by illusions.

If the inhalations be continued, the patient passes into the condition of complete insensibility. In women and children, and males reduced by illness, the production of insensibility is quietly attained, if the anæsthetics be not inhaled too rapidly. The stage of insensibility is preceded by a tetanic, convulsive stage, in which the voluntary muscular system and the respiratory muscles become rigid; the breathing stertorous, the face cyanosed.

This condition of rigidity is similar to, if not identical with, the tetanic stage of epileptic paroxysm.

If the inhalation be pushed still further, the tetanic rigidity subsides, the cynanosis disappears, the breathing proceeds quietly, and the state of complete muscular relaxation and loss of reflex movement is established.

At this time the surface is usually cool, and bathed with profuse perspiration, the countenance is placid, the eyes are

closed, the pupils rather contracted than dilated, the respiration easy, but more shallow than normal; the pulse slower—it may be feebler, it may be stronger than in health, the functions of the cerebrum are suspended, only the centres presiding over respiration and circulation continues in action.

The main deviations observed from these successive stages, when administering bromide of ethyl, are, that we have, practically, no stage of faucial irritation beyond the choky sensation; a scarcely noticeable stage of excitement, and the period of rigidity is very short and not pronounced; no cerebral intoxication, breathing in early stage decidedly quickened, the face never cyanosed, but constantly flushed, the ears red, the eyes injected, with the pupils more or less dilated.

My mode of administration is to take a towel and form of it a closely fitting cone, having previously placed a layer of firm close paper (usually a leaf from a good quality printed pamphlet) between the folds.

I prefer a towel to all patent inhalers, for I have found none to so well exclude the admixture of air. My attention is then given to instructing the patient in the part he is to perform, to make it most comfortable to himself, and speedy in action. I wish to impress this point, for it is a most important one. I tell the patient it is going to feel choky, but that it will not choke him; and the best way to get rid of the choky feeling, is just to blow it out with the mouth wide open. Now, of course, they cannot blow out, without taking the inspiration, but this seldom, if ever, occurs to the mind of the patient. I then practice the patient at blowing into the towel for half a minute before putting any anæsthetic in it, leaving this impression, that he must blow it out, the last one upon his mind. I then turn dr.j. (one drachm) of the ethyl bromide into the apex of the cone, and place it closely over the mouth and nose, telling them at the same time to blow it out. Usually three or four whiffs serve to produce loss of consciousness, and in a half minute (a minute at the longest) complete anæsthesia is produced. Just so soon as this is attained, I remove the towel altogether. The stage of complete anæsthesia lasts from a minute and a half to two minutes, in which time many painful operations can be completed.

The patient comes from under the influence of the anæsthetic as if waking from a natural sleep, with the mind perfectly clear and with complete contol of the muscular system.

If my instructions fail to have children inhale the bromide as I wish, and they hold their breath instead of breathing freely, I give the anæsthetic free from admixture of air for about half a minute and then remove the towel a little, to allow them to take one free inspiration of air, but as soon as this is done, I again place the towel over the mouth and nose, when the breathing always proceeds as desired, no further holding of the breath ever having been noted in my experience.

I have often noticed complete insensibility to pain to last for a minute or two after the patient has returned to consciousness, and diminished sensibility to keep up much longer.

Dr. Julian J. Chisholm, of Baltimore, with whom I have had my training in the use of this drug, has administered it somthree thousand (3,000) times, and he, (in his larger experience,) as well as myself, has never seen the slightest indication of harmful results, following or accompanying this careful method of administration.

It is not to be used in long operations, but is eminently suitable for any that can be performed successfully in two minutes

I have found it sufficiently lasting to perform squint operations on very young children; to open into a mastoid abscess, perform optico-ciliary neurotomy, or enucleation of the eye-ball (having first taken up the muscles under cocaine,) and many minor to these.

If the operation is not completed when consciousness returns, after the first administration, or if seen that it will not be completed, do not repeat the administration of bromide, but keep up the anæsthesia with chloroform. When the bromide is repeated or the anæsthesia kept up with chloroform, nausea is certain to follow; whereas, it rarely follows the single administration of the ethyl bromide.

I have never given ether in conjunction with it, but always used chloroform, when a single administration of the ethyl bromide did not produce anæsthesia of sufficiently long duration in which to complete the operation.

Some claim it must be much more dangerous than chloroform or ether, from its power and rapidity of action, but they lose sight of the fact that nitrous oxide has also this rapid action, yet is universally conceded the softest of anæsthetics.

When giving an anæsthetic, it is well for the administrator to keep a sharp notice of the ears, for these are always flushed, but quickly pale on the slightest disturbance to circulation, affording one of the earliest warnings of danger. I have never found it necessary in my experience in giving anæsthetics, to use instruments, with their oftimes consequent laceration, for the purpose of getting the tongue out of the way, to secure free inspiration and expiration.

By forcible extention of the head, with the hand under the chin, by the action of the digastric, stylo-hyoid, mylo-hyoid, and genio-hyoid muscles in this position, the hyoid bone is lifted up, bringing of necessity the larynx with it, and gaining by this means the same end as pulling on the tongue itself.

THE CURE OF EPITHELIOMA.

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[*Concluded.*]

4. *Escharotics.* These remedies for cancers of the skin have long lain under a cloud undeservedly. The advances of modern surgery have cast into obscurity methods that deserved a better fate. Thus they have fallen into the hands of irregular practitioners, have been advertised, and finally have fallen into such disrepute as to lead to their entire neglect.

Nevertheless, for the great majority of cancers of the skin, and with the exceptions mentioned in the preceding paragraphs escharotics form the best, least painful, most thorough, and most generally applicable form of treatment. The purpose for which they are used is often misunderstood. It is not so much the absolute destruction of the tissue in contact with the escharotic that is desired; that layer cannot but be superficial, and could be destroyed in other ways. It is the intense inflammation under and around the destroyed area that does the work. All new tissue is less highly organized than normal tissue, all new tissue breaks down under stimuli which normal tissue resists. Hence we aim to establish, if possible, an inflammatory process of just such intensity as to be beyond the endurance of the newly proliferated epithelial

cells, and yet is within the bounds of tolerance of the maturer, fully developed normal tissues.

A variety of agents are employed for that purpose, some of which do not by any means fulfill the indications set forth above. Such far-reaching and intense escharotics as pure nitric acid and the acid nitrate of mercury and chloride of zinc defeat the very objects for which the remedy is used. They destroy the normal as well as the abnormal tissue; it is impossible to limit their action with any degree of accuracy, they are excessively painful, and they cause an entirely needless amount of deformity. On the other hand nitrate of silver and pyrogallol are hardly more than very mild caustics in whatever form they are applied; they may destroy a very superficial layer fully, but they act as gentle irritants to the deeper tissues and simply stimulate them to accelerated growth.

But in arsenic we have an agent at our command that exactly fulfills the requirements of the case. It can be used in various degrees of concentration, in accordance with the degree of inflammatory action which we desire to set up. It is not poisonous—the inflammation it sets up precluding all possibility of absorption. It is thoroughly manageable, and the amount of pain its application causes is readily borne in almost every case.

It has its limitations as before said. It cannot be used on cancers situated in the immediate proximity of the mucous orifices. Here one of the other methods of eradication must be employed. But wherever the situation is such as to permit its use, it is needless to try any of the others.

The mode of application is as follows: A fresh and stiff paste is made by mixing white arsenious acid and mucilage of acacia. The proportion of the two ingredients varies in different cases. I generally use equal parts of each, which makes a paste of about the right consistency. If the patient is very sensitive, it may be necessary to use one part of arsenic to two or four of acacia. The strongest paste is the best; the more intense the inflammatory action, the more positive the assurance of the impossibility of absorption. I have never, however, seen any symptoms of arsenical intoxication with any of them.

A curetting may or may not have previously been done. It is advisable in cases where the growth is fungating and projects much above the level of the skin, or where the amount of tissue to be destroyed is large. The escharotic acts much better upon an abraded surface.

The paste is now spread thickly and evenly upon a piece of linen, the area covered extending at least half an inch beyond the apparent confines of the growth.

There need be no fear of destroying healthy skin. Healthy skin reacts upon the escharotic and inflames; neoplastic tissue breaks down and dies. A much larger extent of tissue is always destroyed than is apparently affected; but this is due to the fact that the epithelioma extends further than is visible externally. And it is this faculty of the arsenic, to set up an inflammation of such intensity as to cause the breaking down of all the new tissue, that renders it especially valuable to us.

The plaster being put on, it is secured in place by rubber plaster, and the whole covered with absorbent cotton and a bandage.

The pain does not usually commence until a number of hours after the first application. As a rule it is very bearable and does not disturb the patient's sleep. There are cases, however, especially in hyperæsthetic females, when it becomes necessary to give an opiate. A small dose of morphine, 1 8 to 1-4 grain by the stomach at bedtime, is all that is required.

After the first few hours the parts in contact with the arsenic inflame and swell up, and the œdema may spread over a considerable territory. The eyelids may be swollen until the eye is almost closed; the lips and ear may be considerably tumefied. This always alarms the patient, and it is well to warn him of it beforehand. It occurs in consequence of the proximity of the inflammation set up to organs with loose subcutaneous connective tissue meshes which hold a good deal of serum. It is of no importance and gradually subsides.

When the plaster is first removed after twelve hours, the skin around the epithelioma is red, swollen, and angry looking, whilst the growth itself has assumed a slightly dusky

appearance, marked largely however, by the white paste sticking to it. The part should be carefully cleansed with cotton and creolinised warm water, and a fresh application made of the paste.

This should be continued twice a day for a time which depends on the amount of tissue to be destroyed. In very superficial and circumscribed growths, one or two applications may be enough. In others it must be continued for three or four days.

When the destruction is complete, the new growth has turned dark brownish or black in color, and is not sensitive to the touch. It is dead.

The use of the paste is now stopped, and a flax-seed poultice is applied. Your object now is to promote the reactive inflammation of the healthy skin which is in contact with the dead tissue. The more frequently the poultices are renewed, and the better they are kept, the sooner will the necrotic mass be cast off.

After a few hours of poulticing, this yellow line of suppuration will become apparent at the edge of the normal skin. This deepens and broadens, and before long free suppuration is established. The suppuration surface spreads under the mass, and it is gradually cast off as a whole or by piecemeal. We can frequently help the casting off process by a skilful use of forceps and curved scissors.

The length of time that the poultices are required, depends on the mass to be cast off. As a rule two days are sufficient, but I have seen it take eight, in an exceptionally extensive case. There is, of course, no pain after the plaster is discontinued, and the patient does not object at all to the prolonged poulticing.

Finally the last fragment of necrotic tissue has come away, and we have in the place of our epithelioma an open ulcer of larger extent than the original growth itself. It is covered with an abundant layer of healthy pus, and already in those parts where the dead material was first cast off, red granulations are springing up abundantly. The question which now confronts us is: "Have we destroyed all the carcinomatous tissue, and is it safe to let the ulcer heal up?"

The answer is probably, "Yes." No lowly organized and badly vascularized new tissue could stand the brunt of that inflammation. Probably every hyperplastic epithelial cell has been destroyed and cast off.

And here let us remember that certain portions of the tissue which has been destroyed has been cast off some time before other portions, and that the normal tissue underneath has been subjected to considerable poulticing along with the still undetached portions. Heat and moisture will favor vigorous granulation, and we must beware of mistaking such tissue for remnants of the carcinoma.

It is now safe to let the ulcer heal. It was formerly my custom to use iodoform for that purpose; but the objections to its use, especially around the face, were so patent that I have latterly discontinued it. Aristole, ten grains to the ounce of vaseline, may be employed; but nothing gives better results than simple cold cream, ugt. aq. rosæ, or plain zinc oxide ointment. With this, then, the ulcer is dressed as often daily as may be necessary, depending on the amount of secretion; each dressing being preceded by a careful cleansing of the parts with creolinised warm water.

In a day or two the new tissue begins to shoot inwards from the margins of the ulcer. It closes almost visibly, shrinking day by day. All obstacles to normal repair being removed, healing is very rapid. Even the largest are closed in ten days or two weeks.

Under the pressure of the bandage, excessive growth of granulation tissue soon stops. It may be necessary, however, to touch them with the solid stick.

At length, in the place of the epithelioma, we have a smooth scar, thin and somewhat depressed; of proliferating epithelium there is not a trace.

Our task, however, is not quite completed. The scar must be closely watched, inspected week by week. For it may well happen that in spite of all our care, some little odds and ends of cell nests, or even a single one, may have escaped our destructive inflammation, and start the disease again. This will happen chiefly to those not used to the method of treatment, whom the intensity of the reaction has led to use the

escharotic too weak or for too short a time. It happens also in dispensary cases which are not under efficient observation and control. It does not occur if the treatment has been radical.

If then, at the end of four, six, or ten weeks, a small grey nodule appears somewhere in the scar, or if the swelling and induration at the margins of the ulcer does not entirely disappear, or if complete healing does not take place, the treatment must be recommenced. Of course the area now affected is comparatively small. The new nodules and hardened edges must be thoroughly curetted or destroyed with nitric acid, and the arsenical paste reapplied to the spot. It is quite possible that the newly formed scar tissue may break down through the inflammatory process. This is no disadvantage. It will heal again as quickly as before.

Finally, if in four months the scar is found in *statu quo*, growing only whiter and less disfiguring than at first, if the edges where it merges into normal skin are unmarked by any ridges or prominences, traversed by dilated arterioles, we can consider our patient cured.

And if the method herein described is not quick as some others, it is surer, safer, and certainly pleasanter than the more rapid means at our command.

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DISEASES OF CHILDREN.

BY DR. E. VAN GOIDTSNOVEN, ATLANTA, GA.

In my last paper, I treated of Cholera Infantum. Certain groups of symptoms are met with in the study and treatment of diseases of children, which often lead a physician astray, and cause him to mistake one disease for another. Anterior polio-myelitis acuta, commonly called infantile paralysis, is often encountered, and almost as often mistaken for cholera infantum.

Anterior polio-myelitis consists in primary atrophy of the nerve cells of the anterior horns of the spinal cord (motor tract), and in secondary complicating myelitis.

By far the largest number of patients are infants from one to three years of age. The disease often begins with indigestion, intestinal catarrh, or morbid dentition. During dentition the nervous system of a child is in a more irritable state, and, perhaps, more likely to suffer from injurious influences.

This may explain the frequency with which infantile paralysis occurs during the first and second year, and why its incipiency may present some points of analogy with that of cholera infantum. Its progress, however, soon enables one to establish the differentiation: for it evolves into akinesis, wasting of muscular tissue, paralysis and deformities. I refer the reader to the masterly works of Charcot, Leguin, Hammond, etc., for further particulars of that disease, and simply mention it here, in order to caution the practitioner against the possibility of an erroneous diagnosis.

Cholera infantum is frequently followed by ileo-colitis, an inflammation of both the large and small intestines. This inflammation is confined mostly to the mucous membrane, the secretions of which are increased; and an increased peristaltic action having been set up, there is more or less diarrhœa. Oftener, however, ileo-colitis is a destructive disease from the beginning. Cold, irritating ingesta, or decomposition from the food and the production of irritant material from this, may likewise cause it. The appetite is impaired and if the child be nursing, the milk, having an acid smell, is thrown up by the stomach. The resulting diarrhœa is sometimes charged with bloody mucus, and is distinguished from dysentery by its feculence. When the stools contain much blood and mucus, the straining during each operation is invariably very severe. In the treatment of this disease, I have obtained most satisfactory results from the following prescription:

10. R. Hydrargyri chloridi mitis, gr. i.
Bismuthi Salicylatis,
Salolis,
Pulveris carbonis salicis ligni: aa gr xii.

Misce. Tere optime et in chartas duodecim (No. xii.) divide.

Signa. One (1) powder every four (4) hours.

I also insist upon the necessity of washing out the bowels antiseptically, and the prescription, No. 9, given in my last number, answers that purpose very satisfactorily.

THE CURE OF PULMONARY TUBERCULOSIS UPON THE PRINCIPLES OF NUTRITION.*

BY KARL VON RUCK, B. S., M. D., ASHEVILLE, N. C.

How hopeful such a title sounds, and how pleasant it is to contemplate that such a result may attend our efforts in the treatment of this dread disease.

Yet how difficult it is, how much painstaking effort it requires, both by physician and patient, how frequently our brightening hopes are ruthlessly dashed to pieces by intercurrent relapses, and how hard it seems to regain the lost ground, I have impressed upon me almost every day of my life, and I frequently wonder why I did not choose some easier specialty for my professional labors. Not only is the battle with this disease a difficult one, but disappointment to one's ambition for success arises frequently, even when the cure seems almost completed or within easy reach, by the patient mistaking improvement for real recovery, abandoning his and our efforts too early, and serious or even fatal relapses then follow the return to the climate and conditions of life and habits under which the disease was acquired.

These latter disappointments are specially hard to bear, after months of painstaking efforts and interest in a case, which we have prospects of adding to the list of successful ones, and even with the great preponderance of advanced-stage cases, which seek climatic and other treatment at our hands, I am well satisfied that were it not for this too early abandonment of properlefforts, the permanent results which I have heretofore witnessed could have been easily doubled and perhaps trebled.

Another source for regret, and an important cause for the low per centage of permanent recoveries, is the fact that comparatively few cases come under systematic treatment in the early or incipient stage, the patients either being unwilling to take a serious view of their ailment, as long as the general health has not seriously suffered, or a positive diagnosis with

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uncompromising advice having not been given by the patient's physician. Could it be the rule, rather than the exception, that these early-stage cases were placed under conditions of climate, with such management and treatment as even in more advanced cases are still capable of effecting improvement and occasional permament recoveries, I believe the necessity for specifics would be less apparent, and we would succeed even without them in so reducing the mortality, that the disease would be largely robbed of its terrors.

All this will no doubt be more and more appreciated by the patients and their friends in the future, as is already the case with most of the profession, and apart from our employment of prophylactic measures as the "king remedy" for the "king evil" tuberculosis, by which we may hinder the spread of the disease, on our part an early diagnosis and proper advice is all we are responsible for to the patients who consult us.

This responsibility is, I fear, not yet met by the profession in general as fully as it should be, and the time has certainly arrived when failure in diagnosis of the early stage of phthisis should be considered reprehensible and justly deserving of censure. It is the first essential to a cure, and when made may also be coupled with a hopeful prognosis, for even at home much may be accomplished should the patient be poor or entirely unable to secure the additional aids of climate and expert professional management.

At no time will the necessary expense incidental to recovery be less, whether at home or at a resort; on the contrary it will, on an average, cost less than is frequently expended, when by delays more serious and alarming symptoms supervene, and the subsequent unfavorable course leads to the death of the patient.

Mercenary patients may therefore be told that it costs less money and time to recover from the early stage of pulmonary tuberculosis than it will eventually cost to neglect it, and ultimately die from the disease, in spite of more expensive and nevertheless fruitless efforts.

The signs and symptoms of the early stages of consumption are known to every physician who deserves the name, and while their certain recognition requires some training, a

strong suspicion of the presence of the disease is justifiable in the majority of cases, even from the history and from clinical observations alone, without physical or microscopical examination, justifying the less expert or less experienced practitioner to call upon his colleagues for aid and counsel, or in the expression of his apprehensions to the patient or the relatives, who then share the responsibility with him.

Let no physician blunder along because he dislikes to admit his inability to make a sure diagnosis until the disease is so far advanced that the neighbors will make it for him. It is no disgrace to be in doubt where greater experience may find an easy certainty; but it is criminal to jeopardize the prospects for recovery of a fellow-being by pretending a knowledge not possessed; and I believe that candor and truthfulness in such matters will earn the less experienced physician more friends, more confidence and a better standing, both as a physician and as a man, in his community, than the ludicrous assumption of knowing all there is to be known in the numerous brances of medical and surgical practice.

In speaking of early diagnosis, I would call your attention to an easily determined condition of the involved apex, which amounts to a sign of present structural changes, and which, with a little practice, is not difficult of recognition. I am not aware of its particular mention for the purpose of diagnosis by American or English authors. In Germany it is well recognized, and von Ziemssen lays particular stress upon its importance, being present sometimes before, and always in addition to, the other physical evidence. I refer to the relatively lower portion of the affected apex which obtains, whenever the usually first involved upper limit expands less and holds less air than is the case on the still healthy opposite side.

To demonstrate it, we percuss upward above the clavicle to a line around the neck where resonance from lung tissue ceases, and mark this line carefully with a colored pencil. In most cases simple inspection is then enough to recognize the line to stand lower on one side than on the other, either anterior or posterior, or both, and this is ususally so, even in advanced cases, where one upper lobe is, as a rule, further

anced than its fellow. To be accurate, we measure from marked line on the lateral side of the neck to the end of acromian process, and when errors are excluded, a differe of even a quarter inch being shown, we will rarely seek in n for other evidences of structural disease on the short e, there existing no appreciable difference between the two es in health.

The error in diagnosis, most frequently made, is the missing of the tubercular disease, for a simple throat or bronal affection, especially the latter, so long as no marked difence in the percussion note exists. Those less practiced in sical diagnosis, frequently perform percussion, in a way ich cannot possibly show fine shades of difference, to bring which, requires, besides a well-trained ear, a careful applition of the finger, or other pleximeter, a practiced, even oke from the wrist, and the comparison must be made at same stage of the respiratory act. A distinct crepitation, fine rales, noted in auscultation, to occur over a circumibed area involving, for instance, part of an upper lobe, y indeed be due to bronchitis but this kind of circumibed bronchitis is, as a rule, symptomatic of tubercular dise. The ordinary bronchitis is never so circumscribed; on contrary, it is diffused; the auscultatory phenomena are ctically the same on both sides, and of greatest intensity in lower lobes. In the absence of symptomatic catarrhal ns, we have the suppressed vesicular, or slightly harsh vesular respiratory murmur, a change in rhythm or pitch, also cumscribed and easily outlined with a stethoscope.

Take such a case, even before expectoration has made a miscopical examination possible, and watch the temperature, hourly observations, or by tying a maximum thermometer o the axilla, quite frequently a slight febrile movement will o be found present, and this, when the patient is entirely ware of its existence; in addition, a more or less hacking gh, or clearing of the throat is seldom denied, if we interate carefully. Such symptoms, continuing for a week, a nth, or even longer, what can it all mean? How can we l hesitate to diagnose insipient phthisis when, in addition all this, the patient shows an hereditary, or acquired pre-

disposition, has a quickened pulse, is anæmic, shows loss of strength, or is evèn losing flesh?

The diagnosis made, what shall we do with the case to cure it?

The cure of pulmonary tuberculosis is not an easy matter, and I want to say right here, that there is no one single thing which we can advise or do to the exclusion of many others which will assure success or even improvement; there is no single specific or drug to swallow or to inject, no particular air to breathe, no given place to reside in, and no special mode of life to adopt, which we can recommend as the *sole* road to recovery. The treatment to pursue is based upon much broader principles, in the course of which many therapeutic agents may become valuable at one time or another, as aids to nature's efforts toward a recovery, and has for its object the eradication not only of the tubercular process, but also of the predisposition which made it possible for the tubercular process to become established.

The predisposition is already a departure from the physiological standard of nutritive processes, tending toward or already constituting a pathological state. The resulting biochemical changes for which, indeed, we may as yet have no chemical reaction or microscopical demonstration, influencing the conversion of nutritive as well as waste products. Their elaboration, solubility and excretion become slightly modified, tending under certain conditions to accumulation and retention of substances foreign to the organism in health, or to solubility and excretion of partially elaborated nutritive principles, in either case affecting changes in the fluids and solids of the body, favorable to the localization and growth of pathogenic bacteria, either previously present, or accidentally introduced, at this time, from without.

We have thus a coarse example in diabetes mellitus, and can see some explanation for the frequency with which tuberculosis occurs in the subjects of this disease.

We can indeed also conceive, that under certain conditions similar changes may cause contrary results, so as to diminish the liability for infection from a particular disease germ, or

even confer an immunity, the tissues forming a sterile soil for one kind, and a more favorable one for another.

There is a large field for investigation in the line thus only faintly indicated, and the production of highly poisonous substances in the intestinal canal even in apparent health, the formation of toxal-bumins, of leucomains and cadaveric alkaloids, all point to still hidden influences in the chemistry of the living body which probably play a much more important part in the etiology of disease than we at present surmise.

In tuberculosis, for convenience, we call these biochemical changes "predisposition" or the "pre-tubercular stage," the removal of which, as already stated, being as important, if not more so, than are our efforts to eradicate the bacterial manifestations which in my conception are only a step further in the disease process, and become self-limited, if we succeed in returning the organism to a standard of successful resistance.

These are, and ever will remain, the indication for the successful treatment of pulmonary tuberculosis, be that by specifics or other means at our command.

Before, however, considering the utility of any measure which we desire to employ, it is well for us to enquire how nature deals with the disease in her curative efforts.

So many recoveries are now on record, and so frequently are healed tubercular lesions found in post-mortem examinations, that the possibility of a permanent cure requires no adduction of proof.

We have also learned the various histological changes which occur in, and surrounding, the tubercular tissues when the disease follows a favorable course to its permanent arrestment, being essentially the same as follow the introduction of other foreign bodies into living tissue. The foreign substance, in this instance the tubercle, is either extruded by suppuration or it becomes encapsuled.

Were it not for the difficulty or impossibility on the part of nature to entirely expel the tubercular tissue, or the inability on our part to afford surgical aid, and after its accomplishment apply the principles of drainage and antisepsis, no doubt the entire removal (as long as the disease is limited in extent and circumscribed) would be most desirable, as is the case with all

foreign bodies and with tubercular deposits in parts accessible and within reach of such aid.

In the pulmonary affection, while such processes may lead to the desired end, the encapsuling is much more safe and desirable, and must be favored by every means at our command.

Had this principle been fully appreciated by the early experimenters with tuberculin, the production of necrosis of tubercular tissue by comparatively large doses of this agent would not only have appeared as undesirable, but as positively dangerous; for with the necrosis and the attending softening and suppuration, come the dangers of inflammatory extension, septic fever, and possibly, absorption and dissemination of the bacilli, leading, under favorable circumstances, to most formidable pneumonic processes, general miliary tuberculosis and exhaustion of the patient, and apart from tuberculin, this occurs frequently, under the inadequate efforts of nature to expel the tubercular tissue in the ordinary course of the disease.

I have never expected good results from such erroneous application of tuberculin, and have only wondered that the results were not much worse under the system of dosage by which also the nutrition of the patient received one blow after another, and the complications which we should ever strive to avoid were purposely favored. It is, however, true, that when the process is strictly limited to a small portion of lung, and the patient is still vigorous, excavation is not usually attended by such dire results, and a real cure may follow the process, the cavity being small, and, if favorably located, may shrink and become lined with fibrous walls, or may cicatrize and become obliterated entirely.

Frequently the tubercular infiltration is much more extensive than we suspect from our physical examinations, which, no matter how carefully made, depend still upon comparatively coarse means; and a considerable degree of pathological changes must already have occurred before we get evidence of their existence appreciable by the acutest and most practised ear in examination.

When tubercular deposits or other foreign bodies become encapsuled, this occurs by connective-tissue formation upon

the periphery, due to the increased nutritive changes in response to the irritation set up in the surrounding tissues.

In the course of this mode of cure a more or less dense fibrous wall finally surrounds the foreign substance, and by the subsequent shrinking and thickening, the vascularity becomes eventually so much reduced that the encapsuled substance is practically shut out, so to say, from the general circulation, and may remain so for an indefinite time, or until it may have undergone transformations of various kinds.

In pulmonary tuberculosis the completion of such a process requires considerable time, and may be interrupted either by the changes which may occur in the encapsuled tubercular tissue itself, or by disturbances in the nutrient activity upon the periphery. For instance, softening may occur in the partially encapsuled tubercle, leading then to suppuration and excavation ; the circulation may become so inadequate as to favor the occurrence of stasis or thrombosis in the nutrient vessels, and the protecting connective-tissue capsule is then not completed, may become reabsorbed, or break down.

From recent investigations it seems more than probable that the tubercle itself furnishes a certain irritant during its casation which, acting upon the periphery as a stimulant or irritant, favors the connective-tissue formation, but if in excess or if certain injurious influences act from without, the irritation may increase to the production of inflammation with or without suppuration.

According to the quantity and quality of blood freely reaching the locality, and according to otherwise favorable or unfavorable circumstances, the changes for better or worse are rapid or slow, or stationary. In the latter case the tissues themselves become accustomed to the local irritant, and the encapsuling is thus retarded or arrested.

Other things being equal, the logic is unassailable, that the richer the blood is, in its tissue-building elements, and the freer and the less obstructed the circulation to the locality where increased tissue-formation is desired, the surer, quicker and better will be the result.

It follows, therefore, that the process of a cure depends upon the local and general nutrition, and the means which we

may hope to be of benefit in eradicating the tubercular tissue by encapsuling and subsequent pressure, atrophy and absorption must be shown to aid directly or indirectly either the local or general nutrition, or both.

To eradicate the predisposition, we have good reason to depend upon the same means until a specific protective remedy shall have been found.

We know that the leucocytes and the blood-serum are antagonistic to pathogenic micro-organisms, and under favorable conditions have the power to destroy them; we know, too, that the blood of certain species of animals has this power to a greater degree than that of others, and it is also probable that a difference in degree exists in the same animal and in different animals of the same species. We believe, therefore, that the susceptibility to tubercular infection is only relative in the human being and is determined by the state and quality of the tissue cells, the serum of the blood and its cellular elements—in other words, by the local and general nutrition.

Empirically we know, also, that anæmia and other nutritive disturbances favor the occurrence and progress of tuberculosis, and that, in the strong and vigorous with healthy functions, the disease is not likely to occur, or is speedily arrested and recovered from, and that, in the favorable course of this disease, relapses follow from even slight nutritive disturbances.

The key to the arrestment and cure of pulmonary tuberculosis is therefore to be sought in nutrition, local and general, and every remedy must stand or fall as it is useful or useless, to this end, and its greater or lesser value must be estimated by the same standard.

As the means and measures by which we influence nutrition favorably are many and various, and different individuals respond more or less perfectly to one or the other, so the resources at our command are of the greatest variety, and much will depend upon judgment and adoption of the means for the individual case and stage of the disease reached.

(*To be continued.*)

TREATMENT OF A CASE OF BLOOD POISON.

BY SAMUEL H. GREEN, M. D., OAKLAND, GA.

I received into the penitentiary on June 30th, 1891, M. T. W., white, who, at the time, was affected with a chronic case of blood-poisoning, of two years standing. Patient had not passed his water in two weeks, nor had an action in six days.

The same day I removed two large ulcers from his right leg, and the following day, another from his right foot. I then gave him a large dose of saccharated calomel, which produced a free evacuation. Also, the following prescription :

℞ Pot. Acetat. dr. i.
Tr. Buchu, dr. ss.
Spts. Eth. Nit. dr. ss.
Aquæ q. s. dr. ii.
M. Sig. Teaspoonful three times daily.

In twelve hours he passed his water with perfect ease. I dressed his foot and leg with pulv. iodoform, sweet oil and gum camphor, then applying iodoform gauze each day, after being thoroughly cleansed with carbolized water, and a solution of bi-chloride of mercury. He at once began to improve, his appetite becoming better, and the ulcers healing up nicely. The seventh day after being received, the ulcers were entirely healed, and his bowels and kidneys in perfect condition. On the 7th day of July, I put him on this preparation ;

R. Pot. Iodidi, dr. ss.
Tr. Gentian, dr. ss.
Aqua, qs. dr. ii.
M. Sig. Teaspoonful three times daily.

He improved under this treatment very fast. On the 15th day of July, I removed a portion of the tibia. The following day I gave him for incessant vomiting :

R Tr. Opii Camp. dr. iss.
Bismuth, Sub. Nit. dr. ss.
Tr. Ferri Mur. dr. ss.
Aquæ qs. dr. iii.
M. Sig. Teaspoonful three times a day.

On the 2nd of August, an abscess bursted in his left side,

from which I got one pint of pus. Following, he had three convulsions, and began to sink. I injected into the rectum warm water, laudanum and starch, and applied hot poultices to his bowels, whereupon he began to resuscitate. I then gave large doses of salts. By way of diet, I ordered beef tea, toasted light bread, sweet milk and butter. He then began to improve under the treatment, and on the 30th day of November, 1891, I pronounced him a well man. However, the ankle and knee joints of both legs are ankylosed.

THE ACTION OF STRYCHNINE ON THE CEREBRUM.

The majority of authorities attribute the action of strychnine to its influence on the spinal cord and medulla oblongata. These conclusions are warranted not only by the character of the symptoms produced in strychnine-poisoning, but also by the fact that after fatal poisoning by strychnine, large amounts of the alkaloid are to be found in these localities, while but a trace is detectable in the cerebrum. In addition, there are no direct experiments as to the action of strychnine on the cerebrum, and but few observations have been attempted in this connection, and they are mostly of a negative character.

In the Centralblatt fur Klinische Medicin, No. 36, 1891, is an account of some experiments by Dr. Biernacki, who has tested the action of strychnine on the cerebrum by exposing the motor centers of the cortex, determining the weakest possible stimulus which would produce a motor reaction, then injecting strychnine and testing the changes in irritability. His results show that strychnine produces marked reduction in the irritability of the cortex, whether administered subcutaneously or locally applied. It is not clear, however, as to whether strychnine has a direct influence on the gray substance of the cortex or not, since it is possible that the apparent reduction in irritability may be due to the action of this alkaloid on other parts of the central nervous system.—*Therapeutic Gazette.*

Correspondence.

NEW YORK LETTER.

NEW YORK, January 22, 1892.

Small-pox has made its appearance in this city. It seems to have taken root in the Italian colony, at Mulberry street, its source having been directly traced to New Jersey, where the disease has raged with more or less severity for several weeks. The whole of the Health Board corps of vaccinators are hard at work vaccinating all the residents of the Italian colony, and it is expected that over 10,000 persons will be vaccinated within the next few days.

Six cases of small-pox have been discovered within the past few days, all among the Italians of New York, and the houses where these have been living have been thoroughly fumigated, while the bedding on which the patients lay has been destroyed. All the neighboring tenement houses, which swarm with Italians, have been treated in a similar manner, while hourly inspections of the persons remaining in the infected tenements are being made by the medical corps.

At last night's meeting of the section of hygiene at the Academy of Medicine, Dr. A. L. Loomis, speaking of the contagiousness of pulmonary tuberculosis, said: "Tuberculosis must be classed among contagious diseases. The most important question before this meeting is to stop the spread of this contagion. To this end, the first step is to educate the public in this new matter of contagion, to let them know how contagious tuberculosis is, and how it can be prevented. The key-note to this knowledge is cleanliness and out-of-door life. Give the poor more and more fresh air to breathe; give them anything that will make them clean, and, at the same time, educate them about the contagiousness of tuberculosis."

Dr. A. G. Gerster, of the New York Polyclinic, presented recently to the class a young man with chronic inflammation of the deep urethra. He came to the clinic suffering from frequent urination, passing his water every ten or fifteen

minutes. He was given four deep urethral injections of a five per cent. solution of nitrate of silver, and at the end of that time was able to retain his water without difficulty for a period of six hours, all the other general symptoms of chronic urethritis disappearing at the same time.

The injections are made after the patient has urinated. He is then placed on his back and the instrument introduced beyond the cut-off muscle and inserted in the neck of the bladder, but not into the bladder. It must lie in that space situated between the cut-off muscle and the vesical sphincter, as it is in this portion of the urethra that the trouble is situated. Three or five minims of a five per cent. solution of nitrate of silver should be injected once, twice or three times a week, according to the urgency of the case.

Dr. Gerster says that he has seen well informed physicians attempt to cure cases of chronic urethritis of this kind by the indroduction of full-sized sounds.

"You may, by these means," he adds, "aggravate the trouble, but you cannot cure it." In the treatment of urethral diseases, he thinks we must be guided by a clear understanding of the exciting condition. It is a subject that is much neglected, but is one that forms a good proportion of the daily practice of many physicians, and is one well worthy of their attention.

The following is the method adopted at Roosevelt Hospital for the treatment of incomplete abortion. The uterus is emptied of the fœtus as soon as possible, and if the hemorrhage is not profuse, the patient is given a full bath. The extraction is done with all the precautions taken in laparotomy.

The external genitals are thoroughly scrubbed and washed with bi-chloride solution, the patient placed in the lithotomy position, the vagina fornix and cervix scrubbed with soap and water, and disinfected with bi-chloride. The cervix is then cleansed of mucus and washed. An assistant next holds the perineum back, with a speculum, while another pulls down the cervix with a tenaculum, and with the uterus grasped and held through the abdominal walls, the surgeon proceeds, if the cervix is not sufficiently dilated, to dilate it with a metal dilator.

The uterus is then emptied of the ovum, membranes and shreds, by means of the finger, the forceps and curette.

It is then irrigated with bi-chloride solution, and if contraction does not take place and arrest the hemorrhage, tincture of iodine is applied, and in neglected cases, a tamponade of iodoform gauze is introduced, which is gradually removed during the twenty-four hours, commencing after the third hour.

The bladder is emptied by a catheter every twenty-four hours. The patient usually remains a week in the hospital.

The Cartwright Lectures for 1892 were delivered by Prof. Henry F. Osborn, of Columbia College, at the New York Academy of Medicine, at 8 P. M., from February 12th to 19th, 1892. The subject of the lectures was "The Present Problem in Evolution and Heredity." They were listened to by a large and appreciative audience, and were well received.

A large number of out-of-town doctors are at present visiting New York, and the South, it may be safely said, is well represented. There is no end to the operations, clinics, lectures, and discussions on medical subjects that take place in this city every day of the week. Go to the most out of the way clinic, and select even the most disagreeable day for your observation, and you will be surprised to see the large numbers of physicians in attendance from out of town. These are not by any means the pinion members of the profession either, but old and experienced men whose enthusiasm and earnestness for their calling seem to have increased with age. The surgical clinics are the ones most frequently visited, and perhaps no other field in the world can furnish an equal number of interesting surgical cases than can New York. After the work of the day is over these same gentlemen may be seen in the Academy of Medicine listening to discussions with the same eagerness and attention, and the papers that are read in the Academy are frequently excellent in every respect. These discussions are sometimes kept up to a very late hour at night and those who have come to listen to them rarely go away disappointed.

Society Notes.

THE CLINICAL SOCIETY OF MARYLAND.

TWO HUNDRED AND FIFTY-NINTH REGULAR MEETING.

BALTIMORE, DECEMBER 18, 1891.

The Society was called to order by the President, Dr. Robert Johnson.

Dr. C. W. Mitchell read a paper entitled, "After Inflammation—What?"

Dr. Wm. B. Crawford read a paper on "Dust as a Causative Factor in Pulmonary Disease."

The various kinds of dust may be divided into animal, mineral and vegetable. Opinions differ as to which kinds are most dangerous when inhaled. That which is generated in brush factories is animal, and very harmful. Makers of hats, especially felt hats, suffer much from the dust evolved. The vegetable dust that does the greatest and most lasting injury to the lungs is that generated in tobacco factories. This dust has not only a mechanical action, but has also poisonous effects.

It is in connection with the inhalation of mineral dust that the greatest amount of scientific investigation has been made, especially in relation to the diseases called the consumption of grinders, miners, potters, etc. Anthracosis, silicosis, siderosis, shalicosis, tabacosis and other kindred names have been suggested to describe a similar condition produced by various kinds of dust. Zenker has handed down the word "pneumonoxoniosis" to cover all these conditions. The history of these cases is very much alike. They begin with simple bronchitis, which gradually becomes chronic. They are usually non-tuberculous, at least at the beginning. Tuberculous complication is only an accident.

When one is exposed to an atmosphere of dust, the contact of this dust with the sensitive nasal and laryngeal mucous membrane sets up coughing and sneezing, and much of the

dust is expelled, and for a time no harm results, but a continued exposure to this dust causes a congestion of the mucous membrane of the nose and breathing passages, and, in time,an inflammation of the whole tract, the ciliated epithelium loses its power, and dust finds its way to the ultimate ends of the lung tubules. When the individual is asleep or absent from this irritation, the ciliated epithelium gets rid of a large part of this foreign substance and the wandering cells may close around some of this dust and try to carry it off or render it harmless by burying it in a lymphatic gland. Much, however, finds its way either through the epithelium or between the cells into the submucous layer, getting into contact with the connective tissue of the alveoli, and, by irritation, causing an hypertrophy of this tissue, and a condition resembling chronic interstitial pneumonia or fibroid phthisis. The general opinion seems to be that the fibroid condition seems to oppose a direct barrier to the growth and multiplication of the bacillus tuberculosis, and in large tracts of lung tissue converted into this material, often not a bacillus could be detected. In one case of the author, bacilli were found in abundance, and yet two years afterward the man reported himself as entirely well.

The color of expectoration is a prominent sign in these cases. In one of the author's cases, a stoker, the expectoration still continues absolutely black at times and always tinged, although it is almost two years since he gave up his occupation. Examination of this sputum under the microscope showed it to contain in abundance carrier cell, which in all cases contained pigment, and in some instances the black crystalline coal could be recognized within these cells. The pigment and foreign material has a tendency to collect at the apices of the lungs, and is only present at the bases when the dust inhaled is excessive in amount and exposure prolonged.

In diagnosis, physical signs do not yield as much as the microscope. By the microscope we see the cells containing the dust. In the author's cases (4), rales were heard on auscultation, but nothing marked was obtained on percussion.

The prognosis is good if the man has not worked too long at the occupation. The treatment is to take the patient from

his dangerous occupation, when improvement begins at once.

Owners of large factories are adopting stringent prophylactic measures in order that they may not lose so many good workmen. The best methods are (1) to prevent the formation or escape of dust by using wet grinding, or by grinding in closed vessels. This is not always practicable. (2.) To prevent inhalation of dust by wearing respirators, etc. But these are uncomfortable and the men remove them at every opportunity. (3.) The removal of dust as fast as it is produced by using fans and air shafts. This is by far the best plan. Still further, the following rules should be enforced:

(1.) Workmen should change their outer clothing after work. (2.) They should keep their faces and hands as clean as their work will allow. (3.) They should never be allowed to eat in the work-room.

Dr. Randolph Winslow related

A CASE OF ELEPHANTIASIS SCROTI.

J. C., colored, aged 44 years, was admitted to the University Hospital September 7, 1891, on account of enlargement of the scrotum and perineum. His father died of meningitis and his mother of phthisis. Patient is one of seven children, six of whom died of phthisis. He had measles in childhood, typhoid fever at 21, and gonorrhœa about eight years ago. The present disease began about three years ago with slight thickening of the tissues of the scrotum, penis and perineum, the infiltration first showing itself in the skin of the scrotum and increasing slowly until at the time of his admission the scrotum was enormously enlarged and reached one-third of the distance to the knee. There were a number of suppurating sinuses and superficial abscesses in the scrotum and perineum. There was some pain. The tissues of scrotum were brawny and very little impression could be made on them by pressure. The perineum was composed of similar tissue and was enormously hypertrophied. The skin of the penis was also thickened but retained its suppleness and the prepuce could be easily retracted. The patient said that his virile powers were unimpaired. He was a sailor, but had

never been much beyond the coast of this country, and had never resided in a hospital country.

Several efforts to detect the filaria sanguinis hominis were unsuccessful.

The sinuses were incised and a long incision made in the perineum to relieve tension and allow the lymph and blood vessels to empty themselves. He was placed upon iodide of potassium, as syphilis could not be excluded. He did not improve, and excision of the scrotum and perineal hypertrophy was performed October 1st. The skin and subcutaneous tissues were very dense and thick and freely supplied with blood vessels. The testicles were carefully dissected out and were uninjured. The gap in the perineum was closed with sutures, but there was not sufficient tissue to cover the testicles, hence lateral incisions were made in the contiguous skin and slips of skin dissected up and brought over so as to form a new scrotum. The tension was great and the stitches cut out, allowing the gaps to separate considerably. Healing was effected under about five dressings, and he was discharged well on November 8th, relieved of pain and discomfort and ready again to reassume his ordinary avocations.

WM. T. WATSON, M. D., Secy.

FELLOW'S HYPOPHOSPHITE.—I have much pleasure in informing you that I have prescribed your Syrup of the Hypophosphites with most satisfactory results, principal y in cases of cerebral nervous exhaustion. I have found it specially beneficial in cases of tubercular insanity, where it appears to have exerted a calming effect upon the irritable condition of the brain, and so promoted sleep in cases in which the absence of the latter, had been conspicuous.

Yours truly, W. ARMSTRONG. ESQ., M. D., B. S.
16, Brunswick Street, Fitzroy, Melbourne, Australia.

PEACOCK'S BROMIDES.—Dr. R Robbins, of Hartford, Kan., writes that "this is a most excellent preparation; has used it with success in spasms, nervousness, etc.; that it is an excellent remedy for headaches; and adds that he cannot get along without it."

Book Reviews.

THE VEST-POCKET ANATOMIST.—(Founded upon "Gray."—By C. Henri Leonard, A. M., M. D., Professor of Medical and Surgical Diseases of Women, and Clinical Gynecology, Detroit College of Medicine, etc., etc.; Fourteenth Revised Edition, Containing Dissection Hints and Visceral Anatomy.

This is a small book of 296 pages, thoroughly illustrated with plain and colored plates of human anatomy, with explanations of proceedures necessary in regular dissections. As a book for ready reference it will prove valuable, both to the student and the busy practitioner. The plates are clear and distinct, and second only to Gray for the purposes they are intended. R. W. W.

ESSENTIALS OF BACTERIOLOGY.—Being a Concise and Systematic Introduction to the Study of Micro-Organisms, for the Use of Students and Practitioners. By M. V. Ball, M. D., Late Resident Physician German Hospital, Philadelphia, etc., etc. With Seventy-Seven Illustrations, some in colors. W. B. Saunders, Philadelphia, 1891.

This is a handy compend of the important subject of bacteria, which Koch and other eminent bacteriologists have done so much to elucidate and render invaluable to the science of medicine and surgery.

The history, classifications, structure and microscopical nature of micrococci-bacilli and spirille are given in detail, while the methods most approved of microscopical examination are fully explained.

The chapters on reproduction, cultivation, growth and the pathological influences of the fungi are comprehensive and instructive, while the department of special bacteriology will be found invaluable in the study of the subject. R. W. W.

A MANUAL OF HYPODERMATIC MEDICATION.—The treatment of Diseases by the Hypodermic or Subcutaneous Method. By Roberts Bartholow, A. M., M. D., LL. D., Emeritus Professor

f Materia Medica, General Therapeutics and Hygiene in he Jefferson Medical College of Philadelphia; Author of . Treatise on the Practice of Medicine; A Treatise on Iateria Medica and Therapeutics; Author of a Manual of Iedical Electricity, etc., etc. Fifth Edition. Revised and nlarged. J. B. Lippincott & Co., Philadelphia, 1891. Price, 3.00, in cloth.

'his is a neat volume of 540 pages, having been revised and arged four times. It is written in plain and neat style, giv- the author's views and experiments of medication by cutaneous injection, as well as the views of other men of erience in this line of treatment.

'he many late experiments in the treatment of tuberculosis lupus have revived this mode of treatment.

'aluable information is here given in regard to the dosage . menstruum of the drug to be used.

'he name of the author is sufficient to assure us of its merit.

fter a careful examination of its pages, I can truthfully that it is a work that every physician ought to possess. t is a work that is creditable to the author. J. M. C.

. B. FLINT & Co., New York, have in press and ready early he current year, the following books:

. complete system of Gynæcology and Obstetrics, with new illustrations based upon translations from the French Pozzi, Auvard, and others, revised by Chas. Jewett, M. D., nd in leather or half morocco, $8.00.

'lint's Condensed Complete Encyclopædia of Medicine and gery, arranged upon a new system, and embodying the ious methods of treatment employed by eminent practi- ners. The most valuable and complete work of this nature r published. The result of a year's labor of a large corps writers. Leather or half morocco, two volumes, $8.00 per ume. The above works sold by subscription.

lso in press, ready March 1st, the Electro-Therapeutics of naecology, by Augustin H. Goelet, M. D. Cloth bound, 50.

DOUBLE PNEUMONIA COMPLICATED WITH ABORTION.

BY WILLIAM F. WAUGH, M. D.

During the prevalence of influenza last winter, all my cases of pneumonia were treated by the use of hot poultices and the administration of the *Febricide Pills.* These pills contain quinine, acetanilide and *cocaine.* There is nothing secret about them, and the object of this note is not to claim superiority for any special maker of pills, but simply to advert to the merits of the formula. While the pills made by the *Health Restorative Company* were employed for convenience, and proved entirely satisfactory, any reliable retail druggist could prepare them quite as well except for the coating. But the combination is one of very great value, combining, as it does, an efficient antithermic with a cardiac tonic and a third drug quinine, which shares in the action of both the others and has a special effect in combating the tendency to suppuration. Perhaps in no disease do we meet with the indications for this combination so perfectly as in pneumonia. And in the pneumonia prevalent last winter we had an opportunity of putting our methods of treatment to the most severe test offered during the present generation.

My records show that during the grippe period I attended twenty-three cases of lobar pneumonia, all of which recovered. Ten of these were hospital cases; the remainder occurred in my private practice.

Out of this group I have selected the worst case as the one which was in the greatest danger of death. She was a stout German woman, illiterate, living in unsanitary quarters, with an inefficient nurse. Everything was against her; yet she recovered. She was about twenty-four years of age, of good constitution and habits, except that she used beer moderately but regularly. I have learned to look upon this as of bad omen in pneumonia. She had been much disturbed by her baby—about a year old—who had been sick for some time with the influenza. March 1st she was seized with a chill, and presented the characteristic symptoms of pneumonia. The disease rapidly extended to both lungs, until the dyspnœa

was extreme. During the first three days my orders were not carried out by the drunken nurse, who was dismissed on March 3d. By this time the patient was in a pretty bad state, the respiration being carried on by the upper lobes alone; the lips blue; breathing very rapid; temperature running up to 104.5 deg. and pulse 136. Vomiting had been troublesome before her illness, as she was about five months pregnant. It was with difficulty we could get any food to remain in her stomach for a few minutes at a time. During the night of March 5th she aborted, losing but little blood—the fœtus coming away easily. By this time the nursing department had been reconstructed, and the food, medicine and poultices were attended to very nicely. Crisis occurred March 7th, and the case went on to recovery without any untoward incident. The patient was discharged from treatment on March 22d, convalescence being somewhat prolonged by the effects of the abortion, and by the bad hygienic surroundings. Alcoholic stimulants were used throughout in the same quantities the patient had been accustomed to before her illness. Febricide was the only drug given, except a few doses of wine of ergot, a teaspoonful each, just after the abortion. "The case was watched throughout with the utmost solicitude, and the unexpected recovery was looked upon by all who saw it, as a notable instance of the value of the combination employed."

Nor is the treatment of twenty-three cases without a death, during the prevalence of influenza, a record so common as to be undeserving of notice. The great work of Juergensen, in directing attention to the heart as almost the sole source of danger in pneumonia, has never received the general attention it deserves. People recover from pneumonia in spite of their treatment with antimony, veratrum, aconite, or the depressant antipyretics given alone, and that in all sufficient numbers to confirm their medical attendants in the use of these drugs.

But the magnificent results of Juergensen with hundreds of cases, and no deaths, except in the aged, have never been paralleled. His methods of cold baths, quinine, red wine and raw beef, seems too peculiar to find general acceptance in this country, where the cold bath has never really extended beyond hospital practice. The object, however, sought in my own

method of treatment, is precisely the same as that of Juergensen—to sustain the heart, and by combating the fever that saps the strength of the heart and increases its labor. With him I say: It is the heart, always the heart. Here lies the danger; here must be the remedy. Every means we employ for treatment acts for good only, as it strengthens this organ or relieves it of its burdens. Antipyretics accomplish the latter object. It is necessary to see that they do not hurt the patient more by lowering his cardiac power than they do good by lessening his fever.—*Times and Register.*

AN IMPROVED METHOD OF GRAFTING ULCERS.

Dr. Gill, in a letter to the *Lancet*, says that having had an exceptionally large number of chronic ulcers of the leg, which incapacitated the patients from work, and finally brought them into the infirmary, he tried the ordinary methods of grafting, but being disgusted with the very large number of total failures he experienced, he undertook various experiments, and at last adopted the following plan, which he distinctly disclaims as his own, but which consists in adopting and combining the ideas of several people. The success he obtained with this method was so marked that he thinks a large number of practitioners at home and abroad (in India especially, where he found all ulcers very intractable under ordinary treatment) will welcome it. Even when the ulcer is deep, with hard thickened edges and extending all around the limb, the method applies. This is to cleanse the surface well for two or three days with boracic fomentations, and then (contrary to what he was taught) slightly abrade the granulations, just sufficient to cause oozing, and apply the graft directly to the abraded surface, where it is held in position by a small pile made of half-inch squares of green protective, four or five squares being placed one on the top of the other. A graft is thus applied to every square inch of surface.

And now comes the most important thing of all, and which is an idea he received from a friend. This is to encircle the limb with a fold of carbolic gauze, which extends two or three inches above and below the ulcer, where it is attached to the

sound skin by collodion. The ulcer is then thoroughly dredged with boracic powder through the gauze, and the whole is wrapped in a layer of boracic wet lint, which is kept thoroughly moist. As a rule, the dressing is not disturbed for three days, when the lint is removed, and the limb, well irrigated with boracic lotion, the grafts remaining perfectly secure under their heaps of protective, which again is kept in position by the gauze. The limb is then redusted with boracic powder, and done up in the wet lint, which is now changed daily. At the end of ten days the gauze and protective are removed, and each graft will be found as large as a sixpence, while those near the edges will have exercised a spermatic influence, and caused a rapid ingrowing of epithelium.

Since adopting the above plan, Dr. Gill says that he has never lost a single graft, though employed on most unfavorable surfaces—a very different result to the old way of covering the grafts with a large piece of protective which retained some exudations under it, and thus bathed the tender graft in a poisonous medium, with a result that 80 per cent. of them never "took."—*The Cincinnati Lancet-Clinic.*

TREATMENT OF PHOSPHORUS POISONING.

Dr. Bokai (*Le Bulletin Medical*, No. 100, 1891,) communicated a new method of treating phosphorus poisoning. The use of turpentine and the salts of copper, give a mortality of 50 to 60 per cent. The writer has found a solution of potassium permanganate, two to five grammes (thirty grains to one and a half drachms) in one thousand parts of water, to form a chemical antidote. The oxygen of this compound is liberated and unites with the phosphorus to form ortho-phosphoric acid, which is inoffensive. The same reaction takes place in the stomach, and, what is more, the oxide of manganese is transformed into a chloride, and the quantity of oxygen liberated is abundantly sufficient to oxydize the phosphorus present.

Experiments on dogs have demonstrated the efficacy of this treatment; those treated thus, after poisoning with large doses recovered, while the animals used to control the experiment all perished.—*The Cincinnati Lancet-Clinic.*

PURULENT VULVO-VAGINITIS IN LITTLE GIRLS.

Chaumier (*Poitu Medical*, October, 1891) calls attention to the purulent vulvo-vaginitis of little girls, which, according to certain authors, owes its origin to blennorrhagic infection. The writer holds that the disease may also be due to other causes, notwithstanding the presence in the discharge of the gonococcus of Neisser. The disorder is contagious, and is of more frequent occurrence in large cities than in the country. It always exhibits the same aspect, characterized by a thick purulent discharge, agglutination of the great lips and retraction of the vulva and vagina, but without complicating the urethral canal. Vulvo-vaginitis is often accompanied with a slight feverish reaction, loss of appetite, frequent and painful urination, the pain being due solely to the passage of the liquid over inflamed parts. In a case related by the author the disease was complicated with an arthritis of the knee-joint. If the malady is left to itself it may last for a long time, but under proper treatment it will generally yield in from two to two and a half months. The treatment consists in the external applications of lotions and in the vaginal injections of corrosive sublimate, followed by the introduction of salol pencils. Salol must also be given internally.—*Annals of Gynæcology and Pædiatry.*

FISSURES OF THE ANUS IN CHILDREN.

Dr. Braun (*Hospituls-Tidende*, R. 3, Bd. 8, S. 1889) finds the use of lime-water as an addition to milk a frequent cause of constipation, and consequent fissures of the anus in children. Any cause which produces diarrhœa with following constipation will cause it. Constipation, proctitis and severe pains on defecation are the results of a fissure. Hernia and masturbation are possible consequences. The condition may be long lasting, although it is easily discovered when attention is called to it. He treats it by regulating the diet, cleanliness, irrigation of the rectum, and dilatation of the sphincter ani, which is easily done.—*Ex.*

TREATMENT OF PERTUSSIS.

Dr. Hellet says that under the influence of ozone inhalations, lasting a quarter of an hour each day, the number of attacks diminishes, the general condition improves, and the appetite returns in a few days. Dr. Chibret claims that by sprinkling powdered iodoform over the pillow on which the child sleeps, the attacks of coughing are quickly arrested. Dr. Galvagno employs the following formula:

R Resorcin,
Antipyrin, aa gr. xv.
Acid hydrochloric, gtt. x.
Syr. simp., oz. j.
Aqua dest., oz. iij.

Of which from three to five teaspoonfuls are given daily. The average duration of cases thus treated does not exceed fifteen days. Dr. Noevius advises an infusion of thyme (100 parts to 700 parts water), to which are added 50 parts of syrup of marshmallow, and of this from a teaspoonful to a dessertspoonful is given eight or ten times a day, according to the age of the child.—*Bul. Gen. de Therapeutique*, November, 1891.

PRESERVATION OF MEAT FOR TEN YEARS.—A gentleman in New York has just tested the result of preserving a turkey in a refrigerator for ten years. This time having elapsed, the fowl was removed from the refrigerator a short time ago, and after being properly cooked, was eaten by a party of well-known gentlemen. While putrefactive changes seem to have been entirely avoided, it was found that the meat was practically tasteless, and had lost all of its characteristic flavor.—*Scientific American*, December 19, 1891. (*Climatologist.*)

FOR COLD IN THE HEAD.

There is no better remedy than gelsemium. One good, large dose, say ten minims of the fluid extract, taken upon going to bed, will effectually dispose of this troublesome and uncomfortable affection. One dose is usually sufficient.—*Med Summary.*

A NEW METHOD OF TENOTOMY.

The following are the steps of an operation which was performed in a case of post-hemiplegic contracture of the flexors of the fingers, by W. W. Keen, of Philadelphia. An incision was made, beginning just above the pisiform bone, and extending three inches obliquely upward, its upper end being over the tendon of the flexor carpi radialis. All the flexor tendons having been exposed, each tendon was first split along the middle for an extent of an inch and a quarter, and then, at the two ends of this incision, section of the opposite halves of the tendons was made; that is to say, the radical half of the vertical slit, and the ulnar half at the other end. The long loose ends of the divided tendon were then made to glide on each other in a vertical direction over a distance of about half an inch, and sewn together by two transverse sutures. The tendon was thus strengthened to the extent of three-quarters of an inch.—*Med. Age. Jour. A. M. Ass.*

THERAPIE OF HUCKLEBERRY.

Professor Winternitz recommends a decoction of huckleberries (saccinium myrtillus) in the different forms of diarrhœa. He covers the dried berries with cold water and cooks them for two hours, stirring them up quite frequently. After the mass is syrupy-like, he separates it from the remaining berries and presses out the juice from them. He then cools the juice, after which it is ready for use. One to two teacupsful of this juice per diem is the dose.

Winternitz claims that this preparation will act beneficially in the most pernicious cases of diarrhœa.

He uses this decoction in gonorrhœa as an injection, and claims to be very successful with such treatment.—*Blœtter fur Kin. Hydrotherapie.* (*Ex.*)

The attention of our readers is called to the advertisement of H. K. Wampole & Co., which appears on page 28 of this issue. This house is one of long standing, and enjoys a reputation of the highest character. The preparations referred to, we commend specially to the notice of practitioners.

FRACTURE IN THE UPPER THIRD OF THE FEMUR.

Allis (*Medical News*, vol. lix., No. 21) carefully reviews the mechanism of fracture in the upper third of the femur exclusive of the neck. He apparently shows that the treatment ordinarily adopted in such cases cannot possibly produce the best results, and terminates his paper by the following conclusions: After fracture of the shaft, the fragments are bound together by a hinge. The hinge will be short if the vulnerating force was only sufficient to break the bone. If the hinge is short, overlapping can only occur to a very limited degree. In all such cases the "shortening" will be due to an angular displacement. If the vulnerating force is greater than necessary to merely fracture the bone, the unexpended force will tear the hinge freely. When the hinge is loose, overlapping, with or without angular deformity, is possible. The shorter the hinge, the greater will be the control of the upper fragment, through the agency of the lower. Traction on the lower fragment, under all circumstances, is incapable of restoring the long axis of the broken bone. If the hinge is short, traction will draw down the upper fragment, but cannot efface the anterior angular tendency. If the hinge is long, traction will exert but little influence upon the upper fragment. Traction in the oblique direction has no advantage over horizontal extension. The so-called "weakness" after fracture of the femur is not due to deficient bone-repair. "Weakness" is greatest when due to angular deformity, with rotation of fragments. Angular deformity, with rotation of fragments, compels both hip and knee to assume abnormal relations to the trunk. Shortness, due to overlapping, *without* angular deformity or rotation of fragments, is no barrier to heavy, manual labor. Treatment directed to the lower fragment is the probable agency in causing rotation in the lower fragment. No surface treatment can insure a useful limb. Osteotomy has corrected many a faulty union after months of wasted time. The convertion of a sealed (simple) fracture into an exposed (compound) one offers the only possible means for accurate diagnosis, and the only possible

method of rational treatment. Patients and surgeons who stop short of this proceedure must compromise with best results.—*The Therapeutic Gazette.*

THE VALUE OF BI-CHLORIDE OF MERCURY IN THE TREATMENT OF URETHRITIS.

BREWER (*International Journal of Surgery*, November, 1881) reiterates his confidence in the efficacy of bi-chloride of mercury in the treatment of urethritis. His method was as follows: At the first visit the patient was instructed in the proper use of a syringe, and was given a large amount of a solution of bi-chloride of mercury, varying in strength from 1: 16,000 to 1: 50,000, according to the sensitiveness of his urethra, and the stage of the disease. This he was instructed to use twice daily, by taking ten injections in the morning, and ten at night, holding each one in the uretha one minute to imitate as nearly as possible the result of irrigation. The patient was seen three times a week. As soon as the discharge lost its purulent character, bi-chloride was suspended and a mild astringent was substituted, preferably bismuth suspended in water. In the fifty five cases treated in this way, five were not benefitted, after an average employment of the method for seven days. In the remaining fifty cases, the average length of time necessary to effect a change in the discharge from pus to a thin watery secretion was a fraction over eight days. The discharge entirely disappeared on an average of twenty-one days. Epididymitis occurred in three of these cases, and posterior urethritis was developed in two. The reporter very fairly states that these statistics are of little value from a scientific point of view, since the cessation of the discharge can by no means be considered as an index that the disease has been cured. He offers his conclusions not so much on the basis of these cases, as upon a very large personal experience, and states positively that the judicious use of bi-chloride of mercury in cases of acute gonorrhœal urethritis is attended with better results in subduing the painful and disagreeable features of the disease, than is any other agent. The recovery is more rapid and permanent, and the frequency of inflammatory complications is greatly reduced.— *The Therapeutic Gazette.*

CARPETS AND INFECTION.

Attention is called to this important matter, and all thinking people will at once recognize that in the carpet lurks the germ of many a disease. Frequently a carpet is made necessary on account of the flimsy character of the poorly joined floors, and the accumulations of dirt that fill the crevices, together with the warmth that the carpet affords, form an excellent breeding-place and medium for micro-organisms. Then come the broom and dust-brush which disseminate those germs that were deposited with the dust, and the sunbeam shows us how beautifully the housemaid has aided nature in diffusing the ripe, warm, well-dried, and nourished bacteria.

One can shut his eyes and see the vision of the housemaid, with a towel wrapped around her head, enveloped in a cloud of dust, energetically detaching the myriads of germs from their safe hiding-places; great-grandmothers gloried in their polished floors, and their children inaugurated the wet tea-leaf when the carpet came into general use.

The patent sweeper is a great gain from an hygienic point of view, and if the people will tightly tack down their carpets on a bare floor, they should at least sprinkle it when swept with a patent sweeper, abolish the broom, and once a week wipe up the whole floor with a cloth well saturated with a solution of carbolic acid, creolis, Platt's chloride, or some other such material.

Once a year every carpet in the house should go through the steam-cleaner, and the floor should be scoured with boiling water and carbolic soap. An architect should at the present day be thoroughly posted as to the requirements of hygiene; he can be an apostle of health to the same extent as the physician.

Every house should have a well-laid floor with corners rounded, and this should be required by law. In the large cities the plumbing laws and their enforcement are saving lives, but there is no law to attack the lurking germ in the cracks and crevices of the "bonus building." Let such be made.—*Med. News*, December 12, 1891. (*Climatologist.*)

INFLUENZA COLDS.

"Few remedies are more reliable, and act better as a preventive, or lessen the distressing symptoms of an influenza cold than the following mixture :

R Sodii salicylas, dram jss.
Liq. ammon. acet., oz. ij.
Aq. camph., ad oz. vj.
Misce. Capt. : oz ss. omnis 3tiis horis.

If this be taken every two or three hours when the first symptoms of cold come on, it will usually ward off the attack."—*British and Colonial Druggist.*

THE TREATMENT OF ILEUS.

Dr. Aufrecht attributes the sudden arrest of vomiting when the stomach is distended to a dislocation which is produced by the distended intestine forcing the œsophagus against the edge of the opening in the diaphragm through which the œsophagus passes. In stercoracecus vomiting, repeated washings of the stomach will not only act beneficially by removing the contents, but will prevent injury from absorption. Morphine, hypodermatically, is advised in all cases of ileus, and large enemata have been abandoned.—*Therapiutische Monatshefte.*

ATROPINE IN HEART DISEASES.

DR. CARDARELLI (*Norsk Magazin for Loegevindenskaben*, No. 4, 1891) has found that atropine in doses of one-half to two milligrammes (1-128th to 1-32d of a grain) injected subcutaneously removes the inhibitory influence of the pneumogastric.

The pulse increases in frequency and the blood pressure diminishes. Hence atropine is indicated in irritation of the pneumogastric. Whenever a slow pulse, with dizziness, convulsions and syncope, are present, atropine is indicated.—*The Medical and Surgical Reporter.*

Editorial.

COLLAPSE FROM PERFORATION OF CÆCUM OR APPENDIX.

The consideration of disorders in the right iliac region having occupied a prominent place in medical literature for some years, it is a notable fact that little attention has been directed to one class of cases, requiring early recognition and prompt action for their relief.

In localized inflammation and perforation of the cæcum or appendix, collapse ensues without premonitory constitutional disturbance, and the prostration of the vital forces is so sudden that death occurs in a few hours, or, at most, a few days after the first indications of trouble.

Much has been said in regard to the relative advantages of medical treatment and surgical measures in typhlitis and appendicitis, which implies a comparatively slow progress of inflammation in the tissues of the cæcum or appendix vermiformis under certain conditions of the structures involved. But in the fulminating developments connected with perforation and discharge of fæcal matter into the peritoneal cavity, there can be no question in regard to the urgency of surgical interference, and the great disideratum is to make timely diagnosis with a view to prompt action.

The insidious character of the symptoms, like those apparently mild cases of typhoid, or, more properly, enteric fever, in which a small perforation of the ileum leads to fatal collapse is calculated to mislead the practitioner, whether physician or surgeon, as to the nature of the change which takes place

Stangely enough, the local manifestations are of so slight a character as scarcely to have attracted the attention of the patient, and perhaps the regular family attendant has not been called until perforation has actually led to marked vital depression. If not on the look out for the true cause, the premonitory local disturbance may be ignored in seeking to arouse the patient from the incipient collapse; and it is only after failure to relieve the prostration that a correct history

of the incipient stage of the disorder leads to a proper diagnosis. A surgeon is then summoned, with the intimation such as the writer has received on several occasions, to come prepared for a laparotomy, when the opportunity has already passed for affording any relief by surgical interference in the case.

The important matter of determining in advance of perforation what is the nature of the case, cannot be decided when the patient has not been seen by physician or surgeon; but in a large proportion of cases the patient has come under professional care while the local modifications admit of examination. It is, then, at this stage of the inflammatory action that we need light upon the seat of disorder and the structural changes which are in progress. Those who have had most experience in diagnosing the disturbances of the right iliac region are not prepared to lay down any invariable rules by which these points can be settled. It is simply an impossibility to define what is the exact pathological state of the parts involved, and hence the only available mode for a satisfactory diagnosis is an exploratory operation.

The writer holds the same view now that was presented by him in a paper presented to the surgical section of the American Medical Association in 1886, on "Surgical Relations of the Ileo-Cæcal Region." It was then set forth that "in cases of doubtful diagnosis, presenting reasonable grounds for the conviction that there exists a disease calling for operative interference, exploratory laparotomy should be resorted to at an early stage, after other modes of treatment have failed to afford relief; and the consequences of this opening the abdominal cavity, where operations upon the contained organs are not undertaken, are not generally serious." Of course, no time should be lost when the evidence of perforation exists; but the point here made is that this result should be anticipated whenever the indications of inflammation of cæcum or the appendix afford a sufficient reason to expect that perforation of their coats may ensue. The consequences of such a lesion are of such a grave nature, not simply by the peritonitis and necrosis of adjacent tissues, but from the sudden supervention of collapse, that considerable responsibility

attaches to delay in ascertaining the exact conditions involved by a surgical procedure. Those precautionary measures, which may avert a great calamity, become conservatism instead of being classed as rashness, and temerity, with discretion, is the highest and noblest attribute of the surgeon.

J. McF. G.

SUNDAY FUNERALS.

In glancing over the pages of the *Annals of Hygiene*, we find the following absurd editorial on a very absurd law:

"SUNDAY FUNERALS IN PHILADELPHIA.—For many reasons, we can assure those who are interested in sanitary reform that they have the hearty sympathy of Archbishop Ryan, of the Archdiocese of Philadelphia, and that, whenever required, they can count upon his earnest co-operation. The latest evidence of this fact we note in the order issued against Sunday funerals, which provides that no permits will be issued for funerals to take place on Sundays, except in cases of extreme necessity.

"When, by reason of death from contagious disease, it is necessary to permit the interment of a body on Sunday, only a hearse or wagon and not more than three carriages will be allowed to enter the cemeteries."

First of all, we should like to be informed as to where the point of sanitation, or so-called sanitary reform, enters into the question of funerals taking place either Sunday, Monday or Tuesday, or upon any other day of the week.

Just here we wish to take issue with Archbishop Ryan, and denounce his proclamation as a very unjust one. It is a thrust at the workingman. For instance, here is a poor workingman, with a wife and four small children to support upon a pittance of 75 cents per day, earned, perhaps, by slaving away for sixteen or eighteen hours; at 12 o'clock on Friday night his wife dies, and he must of necessity lose Saturday from his work. Now, by this law, he must hurry the unfortunate woman away to her last resting place almost ere he has had time to collect the thoughts running through his troubled brain, or the spirit of the dead to have wended

its way from the cold and lifeless body, or else he must lose Monday, also, from his labors, and this, added to the expenses of the funeral, is unnecessarily actually taking bread from the mouths of the half-naked, half-starved children, not to speak of the possibility of his returning Tuesday only to be told that his place had to be supplied by another.

Such an abominable piece of arrogance and outraged justice should be countenanced by no intelligent and justice-loving people.

To the Alumni of the Southern Medical College:

The undersigned, after due deliberation upon the matter, have decided to issue this call to all the graduates of the Southern Medical College to meet in Atlanta, Ga., March 3d, at 9 o'clock a. m., in the halls of the college building, to organize an alumni association, such association to meet each year, and during its session to be represented in the regular annual commencement exercises by an orator appointed by the association the previous year.

The association shall have for its object the social and professional advancement of its members.

In view of the fact that graduates of other institutions of note have formed similar organizations, we issue this formal call.

On the evening of the 3d, the first of a series of annual banquets will be held in conjunction with that of the Southern Medical Society. All wishing to secure plates for same will please send their names by February 20th to Dr. John W. Price, West End, Atlanta, Ga.

(Signed): THOS. CARR AVARY,
JNO. W. PRICE,
C. C. GREENE,
A. AVARY,
W. B. PARKS,
A. DAWSON,
N. O. HARRIS,
C. E. JOHNSON,
E. VAN GOIDTSNOVEN.

DEATH OF DR. HARRY CRUMLEY.

It is with the profoundest sense of regret that we feel called upon to make mention of the death of Dr. Harry Crumley, of Chattanooga, who died in that city January 25th, of pneumonia, after a brief illness.

Although young in years, he was looked upon as one of the foremost physicians of the city in which he lived, and held the chairs of Anatomy, and Diseases of the Mind and Nervous System, in the Chattanooga Medical College. For two years previous to his settlement in Chattanooga, he was physician to the Dayton and Columbus Insane Asylums.

In him the profession will recognize the loss of brilliant and gifted genius, and the laity, a skilled physician and benefactor.

WE HAVE just received a copy of the Medical Fortnightly, the new St. Louis journal, published by Dr. Bransford Lewis. It is a model of neatness, and presents a corps of collaborators that is sure to win for it general favor.

THE DOCTORS' WEEKLY, a bright, spicy and newsy weekly journal, published at New York, by Dr. Ferdinand King, has been received, and is a new departure as to form, being in fact, an eight-page newspaper, devoted to the interests of the profession of New York City and vicinity.

WE ARE in receipt of a case of Dr. G. W. Powell's Rectal Instruments, and can say that they are a most valuable acquisition to any doctor's instrument case, being neat, well made, and admirably adapted to work of that particular kind.

LUMBAGO.

Dr. Lyman Watkins says (*Med. Gleanor*) that ten drops of the tincture of gelsemium every four hours will almost invariably relieve that painful condition, or backache, commonly called lumbago.—*Med. and Surg. Reporter.*

This is paged in

SYR. HYPOPHOS. CO., FELLOWS.

Contains the Essential Elements of the Animal Organization—Potash and lime.

The Oxydizing Agents—Iron and Manganese

The Tonics—Quinine and Strychnine;

And the Vitalizing Constituent—Phosphorus; the whole combined in the form of a Syrup, with a **slightly Alkaline reaction.**

It Differs in Effects from all Analogous Preparations; and it possesses the important properties of being pleasant to thetas te, easily borne by the stomach, and harmless under prolonged use.

It has Gained a Wide Reputation, particularly in the treatment of Pulmonary Tuberculosis, Chronic Bronchitis, and other affections of the respiratory organs. It has also been employed with much success in various nervous and debilitating diseases

Its Curative Power is largely attributable to stimulant, tonic, and nutritive proprieties, by means of which the energy of the system is recruited.

Its action is prompt; stimulating the appetite and the digestion, it promotes assimilation, and enters directly into the circulation with the food products.

The prescribed dose produces a feeling of bouyancy, and removes depression and melancholy; *hence the preparation is of great value in the treatment of mental and nervous affections.* From the fact, also, that it exerts a double tonic influence, and induces a healthy flow of the secretions, its use is indicated in a wide range of diseases.

NOTICE—CAUTION.

The success of Fellows' Syrup of Hypophosphites has tempted certain persons to offer imitations of it for sale. Mr. Fellows, who has examined samples of several of these, **finds that no two of them are identical,** and that all of them differ from the original in composition, in freedom from acid reaction, in susceptibility to the effects of oxygen when exposed to light or heat, **in the property of retaining the strychnine in solution,** and in the medicinal effects.

As these cheap and inefficient substitutes are frequently dispensed instead of the genuine preparation, physicians are earnestly requested, when prescribing the Syrup, to write "Syr. Hypophos. **Fellows.**"

As a further precaution, it is advisable that the Syrup should be ordered in the original bottles; the distinguishing marks which the bottles (and the wrappers surrounding them) bear, can then be examined, and the genuineness—or otherwise—of the contents thereby proved.

Medical Letters may be addressed to

Mr. FELLOWS, 48 Vesey St., N, Y.

Please mention Southern Medical Record.

KUMYSGEN or

Carnrick's Kumyss Tablets.

A Product of Pure, Sweet Milk, Palatable, Nutritious, Easily Digested, and when Dissolved in Water forms a Delicious Effervescent Kumyss.

(Put up in air-tight bottles in two sizes; the larger holding sufficient Tablets for seven twelve-ounce bottles, and the smaller sufficient for three twelve-ounce bottles of Kumyss.)

THIS PREPARATION is presented to the Medical Profession in the convenient form of Tablets, and will be found superior in every respect to ordinary Kumyss, Wine of Milk, Fermented Milk, or any similar preparation.

KUMYSGEN when prepared for use contains every constituent of a perfect Kumyss.

KUMYSGEN is made from fresh, sweet milk, and contains fully thirty per cent. of soluble casein, which is double the amount found in ordinary Kumyss preparations.

KUMYSGEN being in Tablet form, will keep indefinitely; is easily and readily prepared, less expensive than the ordinary variable and perishable Kumyss, and its fermentative action may be regulated at will, thus rendering it available at all times and under all circumstances.

Clinical tests gathered from every quarter of the globe attest its special value in all cases of Gastric and Intestinal Indigestion or Dyspepsia, Pulmonary Consumption, Constipation, Gastric and Intestinal Catarrh, Fevers, Anæmia, Chlorosis, Rickets, Scrofula, Vomiting in Pregnancy, Bright's Disease, Intestinal Ailments of Infants, Cholera Infantum; for young children and for convalescents from all diseases.

The casein being finely subdivided, it is especially valuable for all who require an easily-digested or partially digested Food.

KUMYSGEN is a delicious effervescent Food-Beverage, relished alike by the sick or well.

KUMYSGEN is tonic, stimulant, diuretic, highly nutritious, easily digested, perfectly palatable, and always permanent and uniform in strength.

SAMPLE SENT ON REQUEST.

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APIOLINE.

(CHAPOTEAUT.)

A Reliable Emmenagogue.

e is the true active principle of parsley, Apium Petroselinum, differing from so-called Apiol.
PERTIES.—Physiological experiment on animals demonstrates its special action on the genitals.
les, Apioline produced vascular congestion and excitement, with contraction of the smooth muscular the Uterus. [Report of Faculte de Medicine, Paris. 1889.]
RAPEUTIC APPLICATION.—Recommended in obstinate cases of suppressed or irregular nd in Dysmenorrhœa. [See Clinical Notes by Drs. Stillman, Pelletan, Moer, Blair, Westhaeffer, and næcologists.]
es of Amenorrhœa and non-obstructive Dysmenorrhœa, Apioline is decidedly more reliable than any ion of Apium Petroselinum I have used."

C. H. SCOTT, Denver, Nov, 10, 1890.

sed in phials of 24 capsules containing [4 minims] 20 centigrammes of Apioline in each.

MORRHUOL.

(CHAPOTEAUT.)

E ACTIVE PRINCIPLES OF COD LIVER OIL

uol [Extractum Olei Morrhuæ Alcoholicum] is dispensed in capsules, each of which represents the l qualities of one teaspoonful of od Liver Oil.
ICIPAL EFFECTS.—Increase of appetite, abatement of cough, regularity of digestion and stools, n of sound sleep, and strength.
RAPEUTIC APPLICATION.—In Bronchiti , Phthisis, Rickets, Scrofula, lymphatic conditions y, and where Cod Liver Oil s usually exhibited with advantage.
FESSOR GERMAIN SEE says:—"I employ with success a special ex ract of Cod Liver Oil is Morrhuol, one gramme of which represents twenty-five of the crude drug. It is certain that this rem- ot only tolerated but a sorbed, and that its anti-emaciative properties are the same as the oil."—Regime aire.]
LAPAGE writes—:"Under the influence of Morrhuol [6 to 8 capsules in 24 hours] the cough is rap- ened in violence, the appetite returns, the assimilation of food becomes more perfect, the complexion s in tint and the patient experiences an increase of strength."—Bulletin Therapeutique.
ature concerning "Morrhuol" will be sent on application to the importers.

MORRHUOL CREOSOTO.

(IN CAPSULES.)

Translated from the Tribune Medicale, Jan., 1889

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A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. XXII. ATLANTA, GA., MARCH, 1892. No. 3

Original Articles.

REMARKS ON THE MEDICO-LEGAL ASPECT OF INTESTINAL SURGERY.

(A discussion of Dr. J. D. S. Davis' paper, at the Fourth Annual Meeting of the S. S. & G. Association.)

BY W. E. B. DAVIS, M. D., ROME, GA.

Formerly Surgeon to the Birmingham Hospital of United Charities; President of the Tri-State Medical Society of Alabama, Georgia, and Tennessee; Secretary of the Southern Surgical and Gynecological Association, etc., etc.

There are some embarrassing points in reference to the matter under discussion. It is embarrassing for an expert witness to testify in a case where a surgeon has been operating and left the intestines out for an hour and the patient dies. I have had some experience in hearing witnesses testify in such a case. It is not an easy matter for an expert witness to testify in a case where he wants to protect the surgeon and where the latter does not deserve to be protected.

While Dr. Senn has done a great work in intestinal surgery, I do not consider his gas test as valuable a means of diagnosis as a great many think. It may reveal a perforation, but if it should not, it would be a great risk to rely upon it, without opening the abdomen. Another thing; when the gas is used to distend the intestines we increase the shock, and get a con-

dition which is difficult to relieve; hence, the gas test is altogether unsatisfactory. Even if it could be relied on to show whether the intestine has been injured or not, we may have other viscera injured, and we would let our patient die. An exploratory incision is not dangerous in careful hands, and there will then be an opportunity of arresting hemorrhage.

The recent observations of a number of surgeons show that hemorrhage is more often the cause of death in these cases than we had been led to believe. The intestine is not perforated as often as is taught in the books.

In reference to delay in these operations, it is very dangerous to call a general practitioner into consultation in penetrating wounds of the abdomen. He will caution delay. He will say, "let us wait a little while." If you operate against his will you may subject yourself to criticism. If you lose your patient you will be blamed. It is not a matter of being convicted in the courts, but a man does not want to be harassed and criticised. He does not want public sentiment aroused against him.

Dr. Senn's book was recently introduced in court as testimony in a case in Alabama, and the surgeon who failed to use his gas test was placed before the public at a great disadvantage. Therefore a discussion of this subject by good men will materially help those who are performing these operations. If the transactions of this Association concerning such a subject are presented in court, they will have much to do toward justifying men in resorting to early operative interference. I have seen quite a number of cases, from time to time, whose lives could have been saved had they been operated upon early. If we desire to save the lives of our patients, we must operate *at once.* I have seen an extensive inflammation of the peritoneum in a great many of these cases after 12, 24 and 36 hours. I agree with Dr. Ross that it is unjustifiable for any man to go into the abdomen who has not had the benefits of experimentation on animals. He should learn how to do intestinal operations upon animals and become familiar with the *technique* before attempting to do them on human beings.

Again, the surgeon should not keep the intestines out of the abdominal cavity, for the patient will die unless they are well protected. It is much better to keep them on the inside.

MALARIAL HÆMATURIA.

BY E. H. M. PARHAM, M. D., FORDYCE, ARK.

ANSWER TO DR MCHATTON.

Without wishing to cause Dr. McHatton to continue the discussion of the above important subject longer, or attempting to convince him of an error, to which, perhaps, an over zeal for science may have led him, I have concluded to notice briefly a few remarks contained in his last article. He stated that I said that I controlled the hæmorrhage and altered the abnormal condition of the blood with ergotole, tinct. iron, a a 10 gtts., which, as far as he could see, is an absolute assertion with no opening for escape. I beg leave to assure the doctor that I have no desire to escape from that assertion, but rather repeat it; he also says that the evacuant pleasantry was the result of a typographical error in my first article. In that he is mistaken; the typographical error might have been in his, certainly not in mine, as I had nothing to say about it.

It is strange indeed, that the doctor should discredit my diagnosis, on account of the gratifying results of my treatment, when I had already accepted his symptomatology as correct; there certainly can be no mistake about that. Simple hæmaturia is a disease entirely different from the one under discussion, and it is those with continued fever and other concomitant symptoms alone that we call malarial hæmaturia. I named competent references in a previous article, who are perfectly conversant with the subject under discussion, and probably one or more of them will express their views through the SOUTHERN MEDICAL RECORD before a distant day. The doctor also says that mistaking hæmoglobinuria for hæmaturia was the cause that the disease was erroneously treated; certainly, the discovery cannot be attended with much advantage, since he acknowledges that the mortality has never been less than thirty per cent. While I delight in scientific investigation as well as the doctor, I care very little whether it is the one or the other, provided my efforts are attended with as good results as they have been heretofore.

I have long since believed that it was the duty of every

practicing physician to express his views freely, in a fraternal spirit, in regard to articles which he may think misleading. We are dealing directly with human life and can never recover that which is lost. It was that conviction that prompted me to write what I have; having redeemed what I conceive to be a sacred obligation, and one too that I can never regret, I beg leave to withdraw from further comment, so far as I am individually concerned.

What I have had to say was the result of my own experience, without quoting the experience of others. I might have compiled the experience of others with but little trouble, but any first-course student could have done that. The doctor will excuse me for the last sentence, as I have studiously avoided slang of every kind.

It might not be out of place in this connection to give a brief account of what occurred in relation to the use of peruvian bark, also the use of quinine as soon as separated from the other principles of the bark and having gone into general use, from the year 1830 to the year 1840. I regret very much that I have to refer in part to information obtained through the kindness of two of my elder brothers, (Drs. Thomas & Wm. L. Parham) both of whom were graduates of the University of Pennsylvania. I did an extensive practice in Greensville and Nansemond counties, Va., respectively. Brother William lived and practiced medicine in Nansemond county three or four years and died. I commenced studying medicine with him; Brother Thomas practiced that entire decade in Greensville county, Va., and I do not know two counties that furnish more evidence of malaria than those, and yet the disease called malarial hæmaturia or malarial hæmoglobinuria, was not known in those counties, during that entire decade; and at the same time, peruvian bark and quinine as soon as it could be had was used with the utmost caution, never prescribing either until the patient was thoroughly prepared with a complete intermission of fever.

This state of thing continued some time after that; but after a while quinine became generally used in all states and conditions of malarial troubles by the people generally, without preparing the patient for its use, and without a knowledge of

any evil consequences which might arise from its abuse; and the consequence was, that malarial hæmaturia or malarial hæmoglobinuria appeared in a violent form and was very fatal to those treated with quinine, and unfortunately, from what I have been able to learn, a large majority were treated in that way.

I have made a simple statement of what I know to be facts and leave it to the members of the medical profession to draw such conclusions as their better judgment may direct.

I have my own convictions about it and will act accordingly; others of course will do as they like.

I repeat that I regret very much the necessity of refering to my brothers, and having faithfully performed what I conceive to be my duty, I willingly withdraw from further discussion of the above subject with Dr. McHatton, with no unpleasant recollections of him, believing as I do that it will be attended with good results, inasmuch as it is calculated to cause members of our profession to be more watchful of the effects of remedies, especially quinine, which were the chief objects of my articles.

REPORT OF A CASE OF CARBUNCLE.

BY W. B. COX, M. D., LANDSFORD, S. C.

Thomas R., aged about 40, rode to a town distant about 15 miles, indulged freely in whisky, returned and continued to indulge freely for about ten days, when he sent for me. I found him prostrated, with no appetite, slight elevation of temperature, suffering with insomnia and some gastric irritability. On the left buttock he had a circumscribed swelling about 4 1-2 inches in diameter, which he told me he had discovered shortly after his return from town, to which he had ridden in a wagon with a board thrown across the wagon body for a seat. The swelling was giving him considerable pain. He was still drinking freely.

I gave him a mercurial, to be followed in four or five hours with a saline of sulph. magnesia, injected sulph. morph., gr. 1-4, and sulph. atropia, gr. 1-150, in proximity to the swelling,

smeared the swelling with belladonna ointment, over which I ordered that poultices of hot mush be kept continually applied, and gave him 15 grs. chloral, to be repeated every hour until sleep was produced. I did not withdraw the whisky altogether, but restricted him to 1 1-2 oz. every two hours. I allowed him a generous diet of sweet milk, poached eggs, gruels, etc., and ordered that he drink *ad libitum* chicken broth highly seasoned with pepper. I find that chicken broth—indeed, any other kind of broth—seasoned highly with pepper and taken as hot as can be borne, very agreeable to the stomach after a *debauch.*

The next day the mercurial and saline were repeated. On the third day I observed the cribiform openings so peculiar to carbuncles.

By this time his secretions were in a better condition, and I gave him the following:

℞ Mur. tinct. ferri, ʒ ss.
Sulph. quiniæ, gr. xlviii.
Liq. strychninæ, ʒ i.
Aquæ, q. s., ℥ iii. M.

Sig. Teaspoonful well diluted with water every six hours.

In my gynæcological bag I chanced to have a preparation containing equal parts of carbolic acid, tincture of iodine and glycerine. With absorbent cotton wrapped around the end of a straw I made an application of this preparation to the whole carbuncular mass, boring well into each one of the cribiform openings. I then made three or four successive applications of tincture of iodine, extending the applications some distance beyond the circumference of the swelling. As a dressing, I used iodoform gauze and absorbent cotton secured by a roller bandage drawn moderately tight.

These applications and dressings were renewed every third day. The patient improved rapidly and was dismissed on the fourteenth day from the time I first saw him.

If the carbuncular nature of the swelling had been recognized, and the carbolic acid and iodine treatment had been instituted at first, I believe my patient would have recovered sooner.

The treatment in this case is nothing new. My only reason

for reporting it is that some one who has had no experience with it may be induced to try it. Some prefer using the carbolic acid hypodermically, others locally. I prefer the latter. The latter is certainly less painful, and probably just as efficacious. But in the treatment of carbuncle, as well as in all other inflammatory conditions, we must not neglect constitutional treatment. Secretion and excretion must be kept as near as possible within physiological limits; that is, we must keep in mind the nutrition of the patient.

THE CURE OF PULMONARY TUBERCULOSIS UPON THE PRINCIPLES OF NUTRITION.

BY KARL VON RUCK, B. S., M. D., ASHEVILLE, N. C.

(CONCLUDED.)

Perfect general nutrition, in the sense I employ the word, means the harmonious and normal functional activity of the living organism, and when so much lung has been hopelessly destroyed that an efficient respiratory function is no longer possible, or if other important organs have become, or are previously so damaged that a sufficient degree of nutritive and functional activity is lost, the case has of necessity become incurable.

Constitutional and previous disease may have left everlasting impressions, even the partial removal of which, would be entirely impossible, and for this reason some victims of tuberculosis are doomed to succumb with the moment of infection, and nothing short of its prevention can be of avail to them.

On the other hand, there are perhaps exceptional cases which, under a better constitution, with intact digestive and assimilative powers, have overcome the early manifestations of the disease contracted under a temporary predisposition with little or no aid on our part, and others who might possibly have recovered under less favorable conditions than we believed essential for their welfare. As to those, we need never regret having done our whole duty, but we need to concern ourselves much more seriously with the great majority who die of the disease for want of proper treatment and management at a time when they are in the best condition to derive bene-

fit, and the partial results which we still accomplish in the advanced stages admonish us constantly, that an earlier systematic effort would probably have led to a complete recovery.

Let, therefore, no physician who advises tubercular patients, be satisfied with partial efforts and put his trust in the early stage of the disease, expecting that with little or no aid, nature alone will effect a cure.

Let no one hope to overcome even this stage with a drug prescription or any mode of administration of drug remedies, even if they have the recommendation of specifics and come indorsed by high authorities.

Every patient who has reached an advanced stage and finally dies, was at one time in this early stage where he might perhaps have recovered.

The physician who thinks he has done his duty, even when he has ordered a change of climate, and tells his patient that such a change is all that is essential for his recovery, knows little of the cure of pulmonary tuberculosis. Let him look back over his past experience and enquire what has become of all the tubercular patients to whom he gave prescriptions for hypophosphites, creasote, cod-liver oil and for other drugs, or whom he sent upon a journey for health on a tour of the climatic resorts, first to one place, then to another, the patient at such places being set adrift like a vessel without captain or pilot, and let him realize how few, if any, have made a recovery.

I have done this with 243 cases which I advised and treated upon a combination of such plans in private practice, and of all that number, only 15 were still alive in from two to eight years after they came under my care.* Ten of these were considered to have recovered—a poor chance indeed for the individual case.

I have already stated that every remedy—be th at a drug, a reputed specific, a change of climate, a dietetic, or hygienic measure of whatever nature—must be shown to favorably influence the nutritive processes, either local or general, or both, of the case under consideration, to entitle it to our con-

* "The Management of Pulmonary Phthisis." *Therap. Gazette.* Aug, 15 1889.

fidence and recommendation, and it goes without saying that on the other hand every remedy which is indifferent or acts injuriously, or any conduct of the patient which is detrimental directly or indirectly to the maintaining and increasing of his nutritive processes, we must avoid and interdict.

Perhaps most important among all our resources, is the employment of climate; and the influence it exerts upon the course of tuberculosis need not be sought in some peculiar hidden or mysterious agency which resides, for instance, in Asheville or Colorado Spring, nor in any particular attribute or prominent meteorological feature of a particular climatic resort.

Why, for instance, should we insist that all the benefit climate can bestow must come from a dry atmosphere, and the drier it is the better? If it were so, we could perhaps produce it artificially at home; and although Asheville, N. C., the field of my present labors, has also a just claim to a relatively dry climate, I am not blind to the fact that at certain seasons of the year certain classes of patients do well—yes, as well as anywhere, at places where the air contains much more moisture than the dry air advocates would find sufficient to preclude all chances for improvement. Climate presents such complex conditions and so many factors enter into it, that we cannot narrow its influence down to one single feature of it.

If we look at climatic influences as affecting nutrition, the mystery disappears and we can see how a locality where there is a preponderance of sunshine, in the absence of extreme conditions of temperature and strong winds, with fine scenery, having a pure relatively dry air, free from dust and irritants, allowing of much out-of-door life, with sufficient elevation to favor a better circulation, would allow of better nutritive processes than one where the reverse conditions obtain.

Such a continuous influence has been found very valuable, and my observations upon patients justify the opinion that unless in the presence of active disease or complications, when the patient is under otherwise favorable conditions and proper management, the nutritive functions revive and improve soon after arrival from a less favorable locality.

The otherwise favorable conditions and proper management

are, however, so important that their absence can not only negative all the benefits the climate can bestow, but favor relapses and advances of the disease. The *proper* use of the climate is equally essential, and the amount of out-of-door life, especially the allowable exercise, needs to be regulated and adapted to the conditions of the individual patient, at the time being.

Patients at climatic resorts require care and comforts, and require properly-heated, well-ventilated houses; must have a diet adapted to the conditions of their digestive organs and powers of assimilation, and of the best quality; they must avoid the injurious influences of over-exertion, exposure and other indiscretions, the same as they should at home, *climate furnishing no protection against follies, indiscretions and errors, whether from want of proper knowledge or sufficient self-control.*

Painstaking professional advice based upon the present condition of the patient, admonitions and control, as well as approval and encouragement, special treatment both for the disease itself which can aid, and for other concomitant or intercurrent affections which hinder the best nutritive processes, as for instance, the removal of nasal obstruction to freer respiration, of catarrhal affections of the upper air-passages and of the digestive organs, etc., etc.,—are as essential at the climatic resorts as they are without the advantage of climate, if we desire to keep our patient at his best and clear the way of obstacles to an uninterrupted favorable progress.

The facts are that consumptive patients require an ever-present vigilance on the part of their medical adviser, not only for the removal of the many hindrances to the best nutrition, but for the purpose of preventing their occurrence, and thereby the relapses from the favorable progress already made. One single slip from the ideal course may lose all that has been gained by months of improvement. They also require some systematic observations of their general condition, as well as of the local process in the lung; and frequent records and comparisons by which we can judge of the progress of the case are essential, that we may be able to give the best advice. Every detail of the patient's life must be so arranged and controlled that it will lead to the nearest approach possi-

ble to a perfect functional activity of the organism, and nothing must be too trivial for the managing physician to give his attention to which can be turned to the advantage of the patient. Such management is not likely to be carried out, except in a special institution.

If the patient can have such conditions at home and has to do without them at a climatic resort, I am convinced that he had better take his chances without the advantages of climate.

Let any physician, who cares to try, take an early-stage case of pulmonary tuberculosis in his own house and under his personal control and constant observation; let him carry out painstakingly and persistently the method of management here only indicated; let him bear in mind the principles of nutrition as the object of his endeavors constantly, and weigh every advice or interdiction he gives and every means he employs in the light of its favorable or unfavorable influence upon the local or general nutritive processes, and he will find himself not so helpless in his endeavors as he might believe himself to be, before making the experiment.

Let him also take advantage of the experience of such as have so cared for many cases until his own experience can guide him in all matters, and he will find that he can aid nature sufficiently to crown his labors with considerable success, and this in almost any climate of this country. If the patient can have the important aid of a favorable climate in addition, so much the better.

I have myself labored in this manner in an indifferent climate, and the results obtained are still permanent in over 40 per cent. of the 58 cases treated after from three to six years since their discharge. The majority of these cases were, however, in the early stage.*

The diet in pulmonary tuberculosis I have not yet spoken of, and it would seem strange should I not specially mention it, since I base the success of treatment upon the degree of nutrition in the particular case.

I have heretofore published my views in a paper entitled

* "The Management of Pulmonary Phthisis," *Therapeutic Gazette*, Aug. 15, 1889.

"Some Observations upon the Gastro-Intestinal Disorders and the Diet in Pulmonary Phthisis,"* and have shown there that a proper diet for the best nutrition is, of course, of greatest importance.

There is, however, according to my experience, no possibility of laying down absolute rules as to what and how much all patients shall eat and drink, and constant individualization is here necessary too, as it is in all our therapeutic endeavors.

One of the greatest secrets of success is the prevention and removal of the various digestive disturbances. In their absence, and also in the absence of fever, I allow my patients a liberal choice from the best of a general dietary, interdicting only such articles as may reasonably be feared to disagree or have been found to disagree in the particular case.

When digestive disturbances are already present, the diet becomes necessarily restricted, and much depends then upon the nature of the indigestion, and sometimes also upon the tastes of patients as to the selection.

Milk, however, is the great staple in almost every emergency, and I am much hampered when it, too, cannot be taken in sufficient quantity. Fortunately this is rare, and I have had many patients who, although before trial protesting that it disagreed, have taken milk in the form of koumyss, peptonized, sterilized, or modified some other way, and have done well on it when other food could be given only sparingly or not at all; taking from two to four quarts of milk daily.

As long as we desire to increase the patient's weight, the hydrocarbons must be given liberally, and if possible in excess of the physiological standard; but good milk, bread, butter, the well-cooked cereals and vegetables, and, for those who like it, fat meat, are, as a rule, much more acceptable and attended by better results than fat emulsions, no matter how much their taste may be disguised.

The cooking and serving of food for consumptive patients is also of the greatest importance, and I fancy that often as much depends upon it as upon the particular article given.

In our direct or special treatment of pulmonary tuberculosis,

*_Therapeutic Gazette_, October 15, 1890.

I confess I have little faith in drugs and their continuous administration. Some remedies, as we know, not interfering with the digestive organs, and which are not reducing agents to the blood, may possibly be employed, if we note improvement under their use.

I have for these reasons abstained from the internal use of mercurials, the iodides and creasote; and also the hypodermic injections of iodine and gold chlorides I have not been willing to apply, because of the known destructive effect of iodine upon the blood corpuscles, and because the injections are followed by fever, loss of appetite and *malise*, all of which are contrary to the principles of nutrition.

We cannot hope to cure a patient suffering from wasting disease by reducing him still further in applying remedies which, upon their face, act injuriously.

I have continued the use of tuberculin, first, because I have been able to so administer it as to utterly avoid fever, *malise*, or loss of appetite or any other unfavorable or disagreeable symptom, and because the patients have made remarkable local and general improvement under its use, and a gain in body weight has been observed in almost every case. Second, because from my study and investigation of its action when given in proper doses to suitable cases under certain precautions, I have come to the conclusion that its action upon tubercular tissue is selective, acting as a gentle stimulant or irritant to the periphery of the tubercular tissue, whereby the local nutrition is benefited, the encapsuling of the tubercle is favored and the advance of the disease arrested, through the increase of the circulation, whereby more blood reaches the affected part in which the artificial stimulation is induced. It is therefore an aid to the local nutrition of the affected part, but it is only one aid, and can never be depended upon to the exclusion of many other aids.

I believe that Liebreich's proposition of cantharidin as a remedy is based upon the same principle and has seemed beneficial in the few cases I have had occasion to employ it. Its stimulating and irritant action is not upon tubercular tissue as such, but upon all tissues the subject of present irritation and inflammation. I have, however, seen several ab-

scesses from its use under every antiseptic precaution, and have exceptionally seen the injections followed by rigor and rise of temperature to 102. 5 deg. F., lasting several days, when two-tenths of a milligramme had been injected, which caused me to reduce the doses and would lead me to its abandonment if I should find such occurrences unavoidable.

Nothing can be expected of inhalations with the view of attacking the bacilli, simply because the germicides inhaled and the tubercle bacilli never come in contact. Not even in the mouth, pharynx and larynx have I seen any curative influences upon tubercular disease from such inhalations. The spray from soothing remedies, stimulants and astringents to the mucous membrane of the respiratory tract when inhaled does have a controlling influence upon the catarrhal processes.

The pneumatic cabinet has been a much-abused apparatus because it has been used, not for what it can do, but for what it was hoped to do, namely, to cure consumption.

Patients have been subjected to treatment with it because they had lung disease, instead of because this lung disease presented indications which the cabinet was capable of complying with.

Like many other means, it has not fulfilled our expectations because we have expected the impossible.

Its chief indication in pulmonary tuberculosis is for the production of a better circulation through the lung, which it certainly will accomplish if judiciously applied, and if that were all that is necessary, it would cure the disease.

The good influence upon the circulation is manifested upon the pulse for hours after its use, and also by the circumstantial evidence that in several hundred patients in whose cases I have made more or less use of it, we never had a single occurrence of hemorrhage or bloody expectoration during the periods of its employment, and among these cases were a number who had a history of frequent hemorrhage and bloody sputum. In several cases the present bloody expectoration ceased promptly upon its use.

The pneumatic cabinet is also useful for the accomplishment of a better ventilation of the affected lung, and for th-

recovery of collapsed air-cells and lobules, which would otherwise become atrophied and lost.

Its use is contra-indicated in all acute inflammatory processes and complications, and also where from increased lymphatic absorption, a distinct rise of temperature follows its application. It appears with its employment, as well as with all other useful means, that the influence it exerts is favorable to the local and general nutrition and the restoration or improvement of impaired functions.

As to hydropathic applications, the cold rub, with or without the addition of salt to the water, is certainly beneficial in not only accustoming the body to the more abrupt change of temperature, thereby diminishing or overcoming the liability to take cold; it is in addition a stimulant to the peripheral circulation and to the nervous system, and there are few cases of the disease where its systematic employment is not beneficial.

A bath towel is wrung comparatively dry out of cold water, reduced in temperature upon successive days until we reach 50 deg. F. or even less. The patient is then rapidly rubbed off and dried, the whole procedure requiring less than a minute, unless, if the reaction is not prompt, additional dry friction is necessary.

Such applications should be made regularly before dressing in the morning, and the patient can then take a little exercise out-of-doors before breakfast.

Only the weakest patients may take a hot drink preceding the rubbing, or return to bed for some rest after it.

Simple as this procedure is, it is nevertheless an important aid, and should not be neglected as unimportant just because it is so simple. I have abandoned the shower-baths as being more troublesome and inconvenient and also less agreeable to the patient, while not attended by greater benefits than the simple application spoken of. Systematic exercise, and in bed-patients the substitution of massage, is also highly essential for the best nutrition.

The exercise must, however, remain within the limits short of fatigue in all cases, and this applies to massage as well. Severer exertions, mountain-climbing, and such efforts as

cause shortness of breath must be reserved for a period when the cure is completed, to be then used rather to clinch and to test the permanency of the result, instead of during the period of a cure. If we produce heart fatigue by the exercise, we interfere with, rather than aid, the nutritive processes, and the experience I have recorded elsewhere upon the detrimental effects of over-exertion,* to which I have frequently opportunity of adding, should convince any one that great care and circumspection is essential in strictly regulating both mental and physical exercise or labor for each individual patient according to his present condition.

In conclusion, I beg to urge upon the profession the great importance of early measures and the prompt employment of each and every means with which we can hope to aid recovery, and also my conviction that with the means we now possess we are not indifferently equipped for a successful encounter with the disease in its earlier stages.

MANAGEMENT OF THE PLACENTA.

If there be danger to the child in forcing an early expulsion of the placenta, the danger to the mother is equally as great, and probably greater. The practice is almost certain to cause a retention of portions of the secundines, which worry and fret the uterus, causing prolonged post-partem pains, frequently post-partem hemorrhage, and various other dangerous puerperal accidents, such as metritis, peritonetis, septicemia, etc.

The conclusion of the whole matter is, that unless there be some positive indications for interference, such as post-partem hemorrhage, the physician should wait until spontaneous retraction of the uterus has expelled the placenta into the vagina before making attempts to deliver it. It may then be extracted without fear of injurious consequences.

When physicians generally learn this valuable lesson, post-partem complications, tardy puerperal convalescence, and cases of chronic invalidism, resulting from mismanagement of the third stage of labor, will be much rarer than at the present time.—F. C. FERGUSON, *Indiana Med. Jour.*

* "The Detrimental Effects of Over-exertion on Pulmonary Phthisis," *Therap. Gaz.*, Dec. 15, 1890.

Correspondence.

NEW YORK LETTER.

NEW YORK, February 17, 1862.

The dispensary question is again coming to the front here, and is exciting a great deal of comment in medical circles. The abuse of charity has attained such enormous proportions up to the present time, as to arouse grave concern in the minds of the larger number of medical practitioners of this city. Though there is but little outspoken condemnation among the doctors, there are significant complaints and mutterings on every side. It has been suggested to organize a "Practitioners Protective Association," the main object of which is to be, to induce those who manage dispensaries to restrict attendance of applicants, and to demand of them certificates from physicians or other qualified persons attesting proof of their *utter* inability to pay the ordinary physician's fee. Should this effort prove abortive, it is the aim of the society to commence an open and unremitting warfare against all dispensaries throughout the city. This would certainly be an extraordinary course to pursue, but it must be borne in mind that violent diseases require violent remedies, and there can be no question that free treatment, as carried out in this city, is one of the worst evils a young practitioner has to contend with. This question of free treatment will continue to be agitated here until struggling practitioners will not be deprived of the means of maintaining themselves and their families to the profit of the few who manage these dispensaries for their own interest and ambition.

A very interesting patient was presented to the Clinic of Dr. Janeway at Bellevue Hospital, a few days ago. He was a young man who had had a respiration of 152 a minute for the past three years. He was formerly on the police force of Boston, and in the fall of 1889, while riding on the platform of a car, was thrown violently on the ground, falling on the back of his head and shoulders. He became at once unconscious,

and remained so for ten days afterwards. The case was considered by the physicians who saw it as one without precedent in medical records.

Dr. Van Valsah read a paper last night, before the Section on Practice of the New York Academy of Medicine, on "The Causation and Treatment of Chronic Diarrhœa," and summed up with the following conclusions:

1st. Remove the cause.

2nd. Improve the nutrition and conserve the energy of the patient.

3rd. Secure active elimination and prevent infection.

4th. Cleanse the alimentary canal and keep its contents sweet.

5th. Secure perfect digestion of the food.

6th. Promote absorption and diminish the work of the diseased parts.

Dr. A. H. Smith, in discussing the paper, said there were a few etiological factors occasionally met with in chronic diarrhœa to which the author of the paper had not referred, and one was the malarial element. Every now and then he met with in hospital practice, cases which baffled his efforts at finding a causation, and where the most carefully studied treatment failed to control the course of the diarrhœa, and yet was at once arrested by the exhibition of an antiperiodic.

Just how the malarial poison produces the diarrhœa, he was unable to say, but it was a fact which every one could verify at the bedside.

Speaking in a general way of the treatment of diarrhœa, he thought animal food was very much better than farinaceous for people with this malady, and the reason was that rest is obtained more effectually by throwing the digestive duty on the stomach, inasmuch as animal food is principally digested and absorbed from that organ. Farinaceous food, on the other hand, has to pass the pilorus, and be brought into relation with the fluid of the duodenum before it is in condition for absorption. The indication for the use of animal food was when intestinal digestion was imperfect. Where they had a fatty diarrhœa, he considered ether to be a valuable remedy,

as by its use the function of the pancreas was stimulated, and in that way it exerted a beneficial effect.

Dr. Quinby advised cleaning out the intestinal canal in cases of chronic diarrhœa. It was with great fear and trembling that he commenced treating by means of a cathartic patients who had ten or twelve movements of the bowels a day, but he had never since regretted doing so. He did not wish to be understood as saying that these cases should be treated persistently and permanently in this way, but intermittently. He has had great benefit from large doses of pancreatine in the treatment of the diarrhœa of tubercular patients. He has seen cases where this form of diarrhœa was checked up to the very hour of death, and the colicky pains entirely relieved by large doses of this drug administered every hour or hour and a half after eating.

The trial of a young medical student in this city on a charge of poisoning his wife with an overdose of morphine has aroused a great deal of attention in consequence of the interesting questions involved in the medical jurisprudence of the case. The medical experts on both sides flatly contradicted each other on essential points, making clear to the public the necessity for impartial scientific commissions, appointed by and responsible only to the court, as opposed to the present custom, where medical experts are avowedly employed to take one side or the other, and thus hopelessly muddle the minds of both judge and jury.

The evidence in this case clearly pointed to morphine poisoning, though one of the medical experts for the defense swore that the symptoms were those of hemorrhage of the pores instead of morphine narcosis. To judge from the testimony of the medical experts, taken on the trial, it would appear to be impossible for any one to arrive at a definite conclusion as to the cause of death in the case. The doctors, as is usually the case, differed from each other in almost every instance, as far as their mutual interests were concerned, and though from a medical standpoint they did not help the jury very much, a verdict of murder in the first degree was found against the prisoner.

Dr. J. A. Wyeth is the most enthusiastic advocate of cocaine

in its application to minor surgical operations of any surgeon in New York. All surgical operations of a minor character at the New York Polyclinic are performed under the use of this drug to the complete exclusion of chloroform or ether, at least in the service of Dr. Wyeth. He has developed the technique of cocaine anæsthesia in so perfect a manner that he can cut into a mammary abscess, remove a conical stump of bone, or perform the operation of urethrotomy by the use of this drug without the slightest discomfort to the patient, and with the utmost satisfaction to himself.

THOMASVILLE, GA., February, 1892.

DR. D. H. HOWELL:

In the journals which you sent me a few days ago containing my letters from Paris and Berlin in October, on page 492: "Pion, the originator of the Heamostacie in operation," should be Pean, the originator of the *Hæmostatic forceps* in operations.

On page 493, last line and first word of page 494, in speaking of the endoctreline of arteries in relation to formation of thrombus, it reads, "or disease of this *sort*," but should be or disease of this *part*.

Mr. Armondale is "Armondoli," and *Pean* is Pion.

In December number, page 596, *steam* sterilizer is "straw sterilizer." Page 598, in speaking of the methods of removing remaining lens substance in cataract operations, it reads, "and by upward pressure of the lid to reverse it," should be to *remove*, not "reverse."

There are a few others of spelling, which do not alter the sense, and due to my bad writing, that does not matter.

T. M. MCINTOSH.

Society Notes.

ATLANTA MEDICAL SOCIETY.

ATLANTA, GA., February 16, 1892.

President W. S. Kendrick in the chair.

Dr. Crow presented two specimens from cases, as follows:

CASE I.—Colored, age 26, from Alabama; had been suffering from severe dysmenorrhœa for two or three years, and reduced from loss of blood. Removed one ovary covered with cysts. The other being smaller cirrhotic, was not removed. Case made a good recovery and up in fourteen days. Since the operation had had some menstrual efforts—no flow of blood, but some watery discharge.

CASE II.—Age 29 years; was confined in August last. Saw her December 18th. Found her with fever, pain, chills, continuous purulent vaginal discharge, peritonitis, etc. Gave salines to prepare her, then found placental structure in uterine cavity, curetted. Also found on left side of uterus a small tumor not entirely relieved by the curetting and treatment. Operated two weeks ago and found abscess of ovary. Adhesions had to be broken up and follow broad ligament out to ovary and peal it out. Size of an orange, containing one-half pint of offensive pus. Could not tie it off, douched with ten gallons of hot water. Temperature, 99 degrees at operation. Did not get above 100 degrees after operation until eighth day, then, by a nervous excitement due to nurse leaving, it reached 103, but soon dropped down by use of sedatives and securing a nurse. Same patient since passed a renal calculi. The abscess of ovary was due to sepsis from retained placenta.

Dr. Duncan reported a number of cases of eruption, maculæ form, resembling measles, which he diagnosed erythema, temperature varying from 99 degrees to 100 degrees. Not much sick, but are sent home from school for certificate that it is not scarlet fever. One case in Surgical Institute, there for surgical treatment. He gives mild aperients, tincture rhei;

if the temperature was above 103 degrees, phenacetine. There is a probability of contagiousness.

The President had seen some eight or ten cases in the last few days, and called it roseola; some enlargement of glands of neck. Gives light treatment.

Dr McRae had seen several cases, usually one in a family.

Dr. Cooper had seen several cases, with slight fever, suffusion of eyes, eruption more profuse on body, less on face. Calls it German measles, or roseola.

Dr. Crow, while away, had seen some cases which was diagnosed lymphatic fever, of epidemic form, not contagious, etc. Treats expectantly, and for sake of safety, isolates cases.

Dr. Elkin had seen several cases; called it roseola. Attacks light, and gives light treatment.

Report of case also by Dr. Elkin:

Miss P., age 24. Abscess of left kidney. Eighteen months previous health began to fail, at which time she weighed 160 lbs. She went to Texas for her health, but it failed to benefit her. After returning home she visited one of the leading gynæcologists, who dilated the cervix and urethra, with no special benefit. For months she suffered intense pains in region of kidney, with rigors and fever, which yielded to antimalarial treatment, to return again. After some time pus appeared in urine, general health failing rapidly and losing flesh. Soon after her return, I was called to see her; found evidence of septic absorption, enlargement in region of left kidney. Putting patient under anæsthetic, cutting in, found an abscess of kidney containing about 24 ounces of pus, evacuting it and putting in drainage. Patient improved for several days, when drainage became imperfect, patient grew worse and was brought to Atlanta.

With the assistance of Drs. Cooper, Childs, Glass and Kime, I again cut in to find three pockets filled with pus, from which drainage was not good. Pus burrowing in and around kidney, opened up all pockets, putting in three large drainage tubes and packed wound with iodoform gauze, which was kept up until death of patient from septicæmia. Kidney (post-mortem) was found all honeycombed by destructive processes, scrapings from which did not reveal any special evidence of

tuberculosis microscopically, although patient had two aunts to die of tuberculosis, and the patient had suffered from glandular enlargement. Nothing short of nephrectomy would have relieved case. Her condition after first operation would not warrant such a procedure.

At time of first operation, there had been severe pain in region of the other kidney, and fearing it would become implicated, it was desired to save as much of left kidney as possible, hence nephrectomy was not performed at the time.

Dr. Crow.—I had a similar case, whose father and mother died of tuberculosis. Dr. D. H. Agnew diagnosed trouble with kidney and sent her South. First saw her with temp. 103 deg.; found pus with aspirator, cut down next morning, giving free drainage, washing out with hydrogen peroxide one half water, using it every day for two weeks, discontinued on account of irritation, then used listerine. Patient recovered. Had cystitis; could inflate bladder from incision. The Reference Hand-book of Medicine gives 72 cases of recovery, mine making the 73d. I think free drainage the cause of recovery.

Dr. Hardon reported a case of ovarian cyst, in a woman 58 years of age, 6 years in developing. Resembled a woman 9 months pregnant, some symptoms due to pressure. Operated, drew off most of fluid. Adherent over whole of anterior surface; separated by use of fingers, without tying any points. Posterior surface not adherent. Found a cyst in back upper part, which contained a colloid material, which could not be evacuated, being jelly like; flushed out abdomen, used rubber drainage tube. Had a good pedicle. Patient recovering nicely except cannot evacuate bladder, due to lax condition of bowel wall, and want of tonicity of parts.

Dr. Cooper.—The nearest approach to Dr. Elkin's case that I have had, was a case of peri-nephritic abscess in a woman. No tumor. Thigh flexed, characteristic of such conditions. Aspirated second time before finding pus, then cut down giving drainage. Case report: Tumor in ischio-rectal fossa—rare location for a tumor—existed 15 years. Recognized by patient as a hard tumor. It was against wall of rectum. With one finger in rectum, dissected it out, leaving only the thin rectal wall, brought the tissues together by cat gut sutures,

one row above another, completely closing the cavity and wound, getting union by first intention. Diagnosed as sebacious cyst, found correct on incising it.

Second case. Urethrotomy. Man of 42 years, had stricture for 7 years. Very weak, anæmic, with cystitis, kidney and lung complication. Operated on 3 years previously by the late Dr. Westmoreland. Good effect of operation kept up for sometime, by passage of steel sound, but neglected it and fell into the hands of a homœopath, who treated him with medicines, claiming that he could cure him without operation. Cavity in one lung. Urine 10 to 50 per cent. albumen by volume, chronic crystitis. Tried one month to pass filliform. At last succeeding, operated. From coughing and straining, abscess of lung bursted and came near strangulating patient. Cut down on filliform, through dense cicatricial tissue. No bleeding scarcely. Stitched in full sized catheter for drainage, washing out each day. Left catheter in for 8 1-2 days. Patient did well and had no urethal fever.

Dr. McRae reported a case of convulsions. Woman pregnant. Had one convulsion six weeks previous. Gave chloroform, veratrum viride, etc. Six weeks after first convulsion, they returned. Performed podalic version. Os contracted in mouth of child, retaining it fifteen minutes, although patient was under influence of chloroform. Patient has done well since, and no fever. Dr. McRae also reported one case of sebacious cyt removed from under tongue. Second case in girl 16 years old. Had been developing since she was 4 years old. I did seven urethrotomies last year, and used perineal drainage in them. I believe I was the first to use perineal drainage in Atlanta. One case I operated, on had to do it without guide. Urethra impervious. Find excellent results from the perineal drainage. Use a safety pin and antiseptic dressing and convey discharge to vessel by side of bed. In most of the cases there were fistulous communications.

CLINICAL SOCIETY OF MARYLAND.

The Two Hundred and Sixtieth Regular Meeting, held in Baltimore January 15, 1892. Vice-President R. B. Norment, in the Chair.

Dr. L. McLane Tiffany read a paper entitled "Skin Dimpling in Carcinoma of the Female Mamma."

Dr. Geo. J. Preston read a paper on "Hemorrhage into the Substance of the Spinal Cord, with Report of a Probable Case."

Dr. Harry Friedenwald reported several cases of atropine intoxication from the use of eye-drops.

Dr. R. M. Hall related a case of periodic insanity, associated with salpingitis of the right side, and asked about the advisability of removing the uterine appendage for relief of the mental trouble. Patient has had three attacks, one of which is now on her. They occur about the 11th or 12th of the month. Menstruation occurs at the first of the month. All that now remains of the salpingitis is an enlargement in the right side.

Dr. W. S. Gardner: Although the attacks may not come on at the time of menstruation, yet the two things may be related. If these attacks come on every four weeks, and the woman has menstrual pains regularly, there is a relation of time, if nothing else, and it is possible that by careful watching a connection could be established between them.

Dr. J. F. Martinet: All physicians, and especially gynecologists, recognize that a condition may be developed about the uterus and its appendages which can excite acute mania. I do not arise to answer Dr. Hall's question, but to relate a case in my own practice. I attended the woman in confinement. Her husband confided to me that she was a very willful woman, and had had two attacks of acute mania, each associated with childbirth. During this confinement, no symptoms of mental trouble appeared. On recovery, she went on a visit to the South, her husband remaining at home. On her return some months later, she was in a nervous condition, and finding some things at home not to her liking, she became morose. I saw her on Friday. By Sunday she was in a state

of acute mania. Dr. Rohe, of the State Insane Asylum, believes the mental trouble to be due to uterine excitement, and suggests the removal of the ovaries. I am inclined to think it would be better to postpone the operation for a time. The woman should bear no more children.

Dr. J. E. Michael: I think it is admitted by those who have given the subject attention that the insanity in women due to the puerperal state, pregnancy and diseases of the genital apparatus is a condition which develops in persons predisposed to insanity by inheritance. A case came under my care last summer of a very intelligent young lady who was married under rather unfavorable circumstances, a good deal of excitement attending the wedding. The groom took his bride to his home in Virginia. In one week from the time of the marriage, he brought her back perfectly insane. Her family had heard of the removal of ovaries for the cure of insanity, and suggested this treatment. I opposed it, because I did not think it an operation which ought to be considered under the circumstances. Previous insanity in the family was denied, but, upon careful investigation, I found that this young lady had suffered previous from insanity, lasting several months; also that an uncle had been insane for a number of years; her father, also, had several attacks of insanity. I regarded it as hereditary insanity, the exciting cause being the excitement attending the marriage. I suggested an asylum, and was dismissed. Doctor Wilson got the case, and I was able to follow its course. In three months the symptoms gradually cleared away. I think there is great probability that insanity will again develop.

In Dr. Hall's case there was salpingitis, in which the acute symptoms have passed away, and there is some residuum of the inflammation. The woman has become insane. Her uncle has been insane. She evidently has a predisposition to insanity, and this particular condition has been the exciting cause. I am very much inclined to the view that if this woman had been subjected to ophorectomy, or any other excitement, that insanity would have been the result.

I do not think the operation is indicated in this case more

than in the case of any other exciting cause. I think the operation is decidedly contra-indicated.

The data given by Dr. Hall do not seem to show a definite relation to the menstrual flow. The case is to be regarded simply as one of insanity.

Dr. J. H. Branham: Dr. Michael, judging from the two cases related, seems to be opposed to operation for mental trouble. There is no question but that there are some cases in which benefit is derived from such operation. On the other hand, there are doubtless a great many cases that would be made worse. I know of a case in which mental trouble developed in a young woman which was thought to be associated with some abnormal condition of the uterine appendages. Their removal was effected and the woman developed violent mania just after the operation, and she died in this condition.

If cases are clearly associated with abnormal conditions about the uterus, especially attacks of melancholia occurring near the menstrual period, it seems, from the report of many cases, that great benefit is sometimes derived from these operations.

As to the case in point, there is not enough information before the society to decide whether there is any relation between the menstrual flow and attacks of insanity. Cases of acute salpingitis tend to recover very often if let alone, but frequently the apparent recovery is only a period of relief, and without any other infection from some exciting cause, such as overwork, the trouble recurs and operation may have to be done. In Dr. Hall's case, I think it would be better to wait and see if the mental symptoms cannot be cured without operation. Certainly an operation should not be done within three months.

Dr. A. J. Preston: I think the point that Dr. Michael partly brought out, viz: the careful consideration of the personal and family history of the patient, is most important. There may have been certain things in the life of the individual which may have caused insanity, such as a period of trouble, emotional excitement, great poverty, or some other decided shock. Where the family history shows distinct

heredity, I perfectly agree with Dr. Michael that there should, as a rule, be no attempt to cure by operation. The relationship between the higher brain centers and the genital organs is very close, and irritation of one may cause disturbance in the other. Some of these cases, pointing to uterine irritation, amount simply to hysterical mania. I have seen two or three cases that were relieved temporarily by hypnotism. I saw one in Charcot's clinic suffering with violent mania who was perfectly rational the next day after being hypnotized. Since then I have run across cases now and then in which the hysterical symptoms amounted almost to mania; these symptoms would subside at certain times and were closely related to some genital irritation.

Where there is no distinct hereditary predisposition, and where there is in the patient's personal history the evidences of decided genital irritation, and there is a chance of this irritation still continuing, it would seem to me that an operation would promise the best results. Cases of recurrent mania are among the most obstinate of all forms of mental diseases. If an operation would hold out any hope I should be in favor of advising it, and particularly early in the case. An operation later may do no good, just as in epilepsy an early operation may do good, while a later one may not. As there is in the case under discussion some genital irritation persisting, and the attacks of insanity are periodical, I should be strongly in favor of operation.

Dr. Michael, replying to the remarks of Dr. Branham, said: I did not mean to go into the discussion of operating in cases where there is distinctly a relation between menstruation and the mental condition. I did not deem it a part of the present discussion. I should not hesitate to perform laparotomy in cases where these things exist.

Dr. W. G. Townsend related a case which was under his observation for about three months. A young lady, aged about 23, had hysterical attacks periodically and finally was the subject of acute mania. She had marked tenderness in the right ovarian region. She has been placed in an asylum and her ovaries removed. The results of the operation were not yet

known to Dr. Townsend, but would be ascertained and reported to Dr. Hall.

Dr. Hall: The tumor in the lady's side does not seem to trouble her at all.

I would like to ask if there are any cases on record where perfect recovery has ensued after operation?

Dr. Preston: There are a certain number of such cases on record in which operations have cured the mental symptoms. The operation has not been as successful as was hoped for, perhaps, because it has been performed rather indiscriminately; but there are undoubted cases which have resulted very favorably.

W. T. WATSON, M. D.,
Secretary.

1603 N. Broadway, Baltimore.

GYNECOLOGICAL AND OBSTETRICAL SOCIETY OF MARYLAND.

JANUARY MEETING.

The President, W. E. Moseley, in the chair.

Dr. T. A. Ashby exhibited a specimen of a dermoid cyst which he had recently removed from a single woman 25 years of age. The cyst grew from the left ovary, and had been diagnosed as ovarian cyst. It measured 4 1-2 by 5 1-2 inches in diameter. Its removal was accomplished without trouble, and the patient made prompt recovery.

The interest in the case centered in the character of the cyst, and its contents. It was lined internally with dermal tissue, and at one point the layer covered a small piece of bone. At this point a long twist of hair grew from the skin and measured thirty inches in length. The cyst contained a large collection of sebacious and oily matter, and large strands of hair disconnected from the tumor and matted together in the cyst.

The specimen is an uncommon variety of dermoid cyst. A similar case has been reported by Dr. Munde, of New York. Dr. Ashby referred briefly to dermoid tumors.

They are no doubt due to an irregular derangement of the epiblastic layer of the tissues of the fœtus in embryonic life. The cysts are almost uniformly found in organs and tissues which owe their origin to the layer of the

epiblast, and this circumstance goes to explain the peculiar features which they present. The ovary is a very common location for them, and this fact would tend to prove that the organs of generation originate in the epiblast.

Dr. Wilmer Brinton read a paper on "From Pregnancy, Complicated by Placenta Previa Centralis."

I was summoned at 3:30 o'clock on the morning of September 1st, 1891, to see Mrs. B. T. M. Her second confinement from her reckoning, would take place October 15th. I did not see her until sent for, as stated, on the morning of September 1st. Upon arriving at her home, I found my patient in bed with the history of being awakened some time before I was sent for, by having a few sharp pains, which were followed by a profuse hemorrhage. Upon examining Mrs. M., I found the vagina filled with large clots of blood, the os slightly dilated and very soft, and a placenta presenting. At this time, her pains having ceased, I cleaned out the clots from the vagina, and found the bleeding had stopped. I determined to return home, which I did, leaving orders for my patient to remain quiet, and to send for me at once if the pains or bleeding returned. I was informed before leaving the house that a week previous the patient had had a severe hemorrhage, and knowing I was out of the city, Dr. W. J. Jones, who lives in the immediate vicinity, was sent for. He saw her twice, and, under the treatment and advice he gave her, the bleeding ceased. At 6:30, or about three hours from the time I left the house, I was again sent for. I immediately responded and was soon joined, at my request, by my colleague, Dr. Crouch, and by Dr. J. H. Robinson.

A vaginal examination made at this time found the vagina filled with blood, which was continuing to flow. The os was more dilated and dilatable than it was at my previous examination, and a more complete examination found the placenta presenting, which was of the most complete central variety which I had ever seen. In running my finger around, I found the placenta was completely attached to the mucous membrane of the lower segment of the uterus, with the exception of a small space on the left side, from which the bleeding came, and in which a tear had taken place during the recent contrac

tions which had severed a small portion of the placenta from the attachments. My opinion being verified by the gentlemen present, and as the hemorrhage and pains were continuing, we determined to deliver at once. Chloroform was administered, and introducing my hand, I found the cervix not well dilated, and had some trouble in introducing my hand. I tore rapidly through the placenta at the left side, and found a child presenting vertex. I ruptured the bag of water, and delivered it living by podalic version. In my efforts to do this, I was made conscious for the first time that the uterus contained a second child; so, tying the cord of the first child, and handing it to Dr. Crouch, who was ably assisting me, I introduced my hand for the second time and found the second child presenting shoulder, "*dorso anterior position*," the head being to the mother's left. I turned and immediately delivered a second living child, after which I introduced my hand into the uterus and removed the placenta, which presented a very ragged appearance from my efforts made in passing it at its attachment to the uterus on the left side. After removing the placenta, the vagina and uterus were thoroughly washed out with warm water, during which I discovered the cervix was lacerated on both sides, due, no doubt, to my efforts to deliver the children through an imperfectly delated cervix. Although a large amount of blood was lost during the operative procedures, the woman rallied well from the chloroform, the uterus contracted well, and our patient, within a few hours, presented no special traces of the severe ordeal she had passed through. The children, both males, presented the appearance of having advanced to the seven and a half months' utero gestation, and for two or three hours after birth did well, but later on in the day their extremities became cold, lips blue, heart weak, and they died some seven hours after their birth. The mother did fairly well for about one week, although the pulse and temperature were somewhat above normal—the pulse averaging between 90 and 100, the temperature being about 100. She sat up on the eleventh day, and on the following day I was sent for, and found her with a high temperature and rapid pulse, with some indications of "phlegmasia alba dolens," and for three weeks she was under my constant care, with evidence

of well marked septic complications, and as soon as the tendency for the phlebitis disappeared in one leg, it appeared in the other.

I am satisfied the late septic complications occurred from the lacerated cervix, which healed up kindly on the right side, but not so on the left, which healed slowly by granulations.

Upon my recall to the case on the 11th day, I took charge of the vaginal injections myself. Previous to this time, I had entrusted this to the nurse, much to my regret, for upon my first examination, I was satisfied they had not been thoroughly given ; so every day for several days, I introduced a speculum and with an ordinary piston syringe, I washed out the uterus, the cervix and the vagina, with bi-chloride or carbolic acid sol. and dusted the seat of laceration with either boracic acid or iodoform. Internally was given quinine, phenacetine, large doses of iron, and good food.

The leg was bandaged from time to time with an ordinary roller bandage. Greatly to my relief, my patient finally recovered, and seven weeks after her confinement, returned to her home in Washington.

My object in reporting this case is to impress on the minds of physicians the importance of not temporizing when they have to do with a case of placenta previa.

There is no safety for the mother as long as she remains undelivered. I am satisfied no one can lay down dogmatic rules in every individual case, but my own personal experience has taught me that in performing podalic version, and delivering either rapidly or slowly as the case may indicate, you are working for the best interest of the mother and child, in the majority of cases.

Dr. Wm. P. Chunn.—I have seen only two cases of placenta previa. One I saw with Dr. Neal. The patient had been tamponed with cotton. He took out the cotton, inserted his left hand, and delivered the child by podalic version. Both mother and child did well. I had one patient of my own. It was a marginal implantation, and I thought I could use the forceps better than turn, and I did so. I had some difficulty in getting the forceps on, and failed at first, but the attending physician forced the head firmly down, by external pressure

the forceps were put on and the child delivered. I think I might have done better by podalic version.

Dr. Brinton.—There is no absolute law for the treatment of placenta previa. In my first case the patient was lost by delay. In another case, the woman had bled considerably, but about the time I was called the head came down and the bleeding stopped.

Forceps were put on and the child delivered. I am now satisfied that the first patient could have been saved by prompt action.

In the ten cases of placenta previa which I have seen in practice, only two of the children have been saved. The mothers have all recovered with the one exception as specified above.

Dr. T. A. Ashby.—I think Dr. Brinton did the proper thing in this case. My experience with these cases has been limited, having seen but two. In one, the child was born dead. The mother recovered. The placenta was attached over the entire cervix, and had to be torn away before the child could be delivered.

In the second case, I removed a dead fœtus of five or six months with placenta previa. She had been bleeding for some weeks. She recovered and subsequently gave birth to a living child. More recently I delivered her of another dead fœtus.

With reference to the therapeutic trouble which the doctor's patient had suffered from, I am satisfied that lacerated cervix is a prolific cause of pelvic troubles, and I frequently find laceration of the cervix and involvement of the tubers associated.

The treatment that the doctor suggested, of going into the uterus and washing it out thoroughly, is very good. My own method is somewhat different; I put in a speculum, fill up the vagina with a bichloride solution, and then with some cotton, on an application remove all the debris from the cavity of the uterus. I have treated eight cases in this way in the last year, and in each case got a good result.

I have seen but one case of pure septicæmia, that came on four weeks after confinement. There were no local lesions, and there was nothing in the uterus to be removed. The symptoms came on the twenty-first day after confinement, and she died in about a week.

WILLIAM S. GARDNER, M. D., Secretary.
712 N. Howard St.

Book Reviews.

TEXT BOOK OF MEDICAL JURISPRUDENCE AND TOXICOLOGY.—By John J. Reese, M. D., Professor of Medical Jurisprudence and Toxicology, in University of Pennsylvania. P. Blakiston, Son & Co., Philadelphia.

The third edition of this most excellent text book is now out. As a clear, concise and well arranged text book, we think it is one of the best before the profession. The new edition contains fifty-five more pages than the former, a few subjects having been somewhat enlarged.

In Chapter VI. a new section has been added, and under the head of death by poisoning, a new division has been made into, first, classes and a sub-division, then into orders and arrangement, we think advantageous. In the appendix the former subject of *corpus luteum* of pregnancy has been omitted, and that of protracted voluntary fasting added.

Dr. Reese gives a brief history of the celebrated Signor Giovanni Succi, in New York, and gives some brief remarks touching upon this subject.

Every physician should have a good standard work on Medical Jurisprudence in his library, and I know of none better to be recommended than this work of Dr. Reese.

C. D. R.

W. B. SAUNDERS has now in preparation, and will have ready for delivery about June 1st, 1892, "An American Text Book of Surgery," by Professors Keen, White, Burnett, Conner, Dennis, Park, Nancrede, Pilcher, Senn, Shepherd, Stimson, Thomson and Warren, forming one volume of about 1,200 pages, handsomely illustrated and bound in cloth and sheep. Price of former, $7.00; latter, $8.00.

Also, "An American Text Book of the Theory and Practice of Medicine, according to American Teachers," edited by William Pepper, M. D., L L. D., to be completed in two handsome volumes, of about 1,000 pages each, illustrated. Price per volume, cloth, $5.00; sheep, $6.00; half Russia, $7.00.

Selections and Abstracts

ON EXCISION OF FISTULA IN ANO.

BY A. S. BARLING, M. R. C. S.,
House Surgeon to the North Staffordshire Infirmary.

Fistula in ano is one of those diseases which do not tend to spontaneous cure. Certain slight cases doubtless get well if properly dressed, but in the large majority operative interference is necessary for their relief. The almost universal practice is to lay the sinus open, at the same time dividing the sphincter, and then to pack the gaping wound in such a way as to ensure its healing from the bottom. This mode of treatment is, I venture to submit, neither so simple nor yet so uniformly successful as we are generally given to understand. To carry it to the desired end it is almost essential that the patient should be kept in bed, the treatment not infrequently lasting for some months. I have traced several ordinary cases of fistula after their discharge from hospital, and in almost all the results have been disappointing. The average history seems to be somewhat as follows: The patient is operated on, and then dressed in hospital for a few weeks, during which time he makes rapid progress. He then begins to find the continuous rest irksome, and either on this account or because his bed is wanted, he becomes an out-patient. His friends are instructed, or even shown, how to dress the wound, and he goes out. He attends some time without making much improvement, and is then lost sight of. Some months elapse, when he again appears either very much in the same state as that in which he was last seen, or, worse still, with another fistula due to the bridging over of the wound. This is no fanciful picture, but one based on the careful observation of many cases. Such being the facts, the question naturally arises, can anything be done to shorten the time of cure without endangering its efficacy? Obviously the great drawback is that a large open wound is left to heal by granulation, and

so must of necessity take a long time. Why should the wound be left open? Is it not possible, after removing all the granulation tissue, to sew the wound up with deep stitches, as is done in plastic operations for ruptured perineum. I have done this with very successful results, and will relate one recent case.

The patient was admitted into the North Staffordshire Infirmary, under the care of Mr. Alcock, suffering from a complete fistula, the external opening of which was 1 1-2 in. from the anal orifice, the internal about an inch up the rectum. I began the operation by thoroughly stretching the sphincter, dilating it first by means of a dilator, and then with fingers, until I could introduce my closed fist into the bowel, thus completely paralysing the muscle. I then slit up the fistula in the usual way. The granulating tract was cut and scraped away until two clean raw surfaces were obtained; these were then brought together over their whole extent by four silk stitches, extending deeply into the tissues below the wound, so that the bottom of the wound should be closed as well as the part nearer the skin. The silk had been boiled, and was put in by means of a curved Hagedorn's needle. Nothing untoward happened. The stitches were removed on the tenth day, when the wound was found to have healed soundly by first intention. Now, here is a man who was well in less than a fortnight after this operation, who, I believe under ordinary treatment would not have been cured for at least two months. Further, he had hardly any pain after the operation. The bowels did not move for a week, and the first motion brought about by repeated small doses of cascara, was not painful. The success of the proceedings is very largely due to attention to the following details: (1) Paralyse the sphincter; (2) clear away all granulations; (3) put the stitches in very carefully so as to secure accurate coaptation of the surfaces over their whole extent; (4) use aseptic silk so as to guard against the possibility of stitch abscess. Doubtless many surgeons have done this operation, and I shall be disappointed if I do not learn that it was the common mode of procedure with Hippocrates, but as I do not at present remember to have seen it described, I venture to call attention to it as worthy of notice. *The Lancet*, July 18, 1891, p. 123.—*Braithwaite's Retrospect.*

ANTIKAMNIA.

Our attention has been frequently called during the past year to the claims made by the progenitors of Antikamnia, and as a result after careful investigation we submit the following as a compendium of our examination of its pathological and physiological action.

The therapeutic properties are, Antipyretic, Antithermic, Analgesic and Anodyne. Klemerer of Germany, makes a distinction between antipyretics and antithermics. He says, "Antithermics act only on the temperature; that is, they influence its reduction, while antipyretics influence the *cause* of the high temperature."

Fever is an acute derangement of all functions, the most important of which are acceleration of the heart's beat, and disturbance of the circulation; nervous disturbance; elevation of the bodily temperature; disturbance of nutrition, including secretion.

These four groups of symptoms may have one or two relations. One condition may be the cause of the other, or they may all be simply the result of a common cause. The nervous disturbances of fever may be summed up as a paresis or convulsions, stupor, coma or delirium.

Jergenson has found that there is a regular diurnal variation of temperature in health, precisely similar to that which is known to occur in fever; thus, the 24 hours is, as far as human temperature is concerned, divided into a diurnal and nocturnal period.

Burdon Sanderson says: "The only material difference between the conditions is that in fever the normal is 3.267 deg. F. higher."

In health, there is in man a fixed mean and a normal temperature, having a regular rhythm, and this variation is beyond the control of all disturbing causes, which do not force the organism beyond the condition of health. The maintenance of the normal temperature and its rhythmis dependent upon the nervous system, which within certain limits controls both the production and dissipation of animal heat.

So far as our present knowledge goes, the chief factor in

controlling heat dissipation is the vaso-motor nerves, including in man such nerves as control sweat secretions; these nerves being able by contracting the capillaries of the surface of the body and by drying the secretions of the skin to reduce the loss of heat to a minimum, and by a reverse action to increase it to a maximum. The only nerve centre proven to exist capable of influencing the heat production without affecting the general circulation, is situated in the pons varolii or above it, and whilst it may be a muscular vaso-motor centre, it is more probably an "inhibitory heat centre." Of whichever nature it may be, it must act through subordinate centres situated in the spinal cord.

In fever, vaso-motor paralysis, when produced, is followed by an immediate fall of temperature. Fever is, therefore, a state in which the depressing poison or a depressing peripheral irritation, acts upon the nervous system which regulates the production and dissipation of animal heat. Owing to its depressed state, the inhibition centre does not exert its normal influence upon the system, and consequently tissue change goes on at a rate which results in the production of more heat than normal, and an abnormal destruction and elimination of the materials of the tissue. At the same time the vaso-motor and other heat dissipating centers are so benumbed that they are not called into action by their normal stimulus—elevation of the general bodily temperature, and do not provide for throwing off the animal heat until it becomes so excessive as to call into action, by its excessive stimulation, even their depressed forces. The nerve centers in some cases, seem to be completely inhibited. Antikamnia removes the pressure, by dilating the capillaries and the other vascular vessels, thus causing local congestion to disappear. It reduces the pulse rate, thereby slowing the heart. It controls the vaso-motor nerves, besides calming the whole nervous system, and thus has a general soothing effect. It is a valuable remedy as an antithermic; its action in this regard is well marked, sometimes reducing the temperature 2 deg. to 3 deg. F. in a few hours. It seems to have a better effect on the high evening temperature than upon the high diurnal temperature. An extreme degree of fever, with or without

complications, is dangerous, and must be controlled; in addition to the direct subtraction of heat by cold applications, we must, with caution, have recourse to antipyretic remedies. A distinction must be drawn between fever and its pathogenic agent. Such an antipyretic as Antikamnia may not act on this agent, but may have an independent action, therefore, have only a transitory effect, or it may influence this agent in the same manner that quinine does the germ of malaria or influenza.

An additional advantage gained in typhoid fevers and all gastroenteric fevers by the administration of Antikamnia in moderate doses, is that the alimentary canal is rendered alkaline, and kept in an antiseptic condition, and this is a most important condition to maintain in the treatment of all fevers.

The best results are obtained with Antikamnia when exhibited in small doses, repeated at proper intervals, and the most desirable vehicle is sherry wine or diluted brandy.

The duration of the effect of Antikamnia is longer than that produced by any of the other coal tar derivaties. It also seems indisposed to produce sub-normal temperature, as some of the others do.

In the pyrexia produced by exposure to the rays of the sun, which is common in India and in our large cities during the summer solstice, Antikamnia, in addition to cold douches, is the best remedy. Antikamnia reduces temperature by increasing radiation of heat from the body, and diminishing heat production. It stimulates the glandular system, particularly the sudorific glands. In many cases its action as a diaphoretic is phenomenal.

In some cases it has marked action on the mammary glands, producing an increase in the flow of milk. Antikamnia can be given to children without any ill effects, and is a reliable remedy. In pertussia, it keeps the paroxysms in check, and makes the patient more comfortable than any remedy we have. The cyanosis induced by its administration is *nil*, unless there is a peculiar idiosyncrasy, which is found sometimes, producing manifest heart disturbance. These are to be overcome by stimuli, or intravenous injections of salt.

Antikamnia acts admirably in the after-pains of labor, in dysmenorrhœa, hemicrania, migraine, ordinary sick or nervous headache, in the pains of locomotor ataxia, the various neuralgias, epilepsy, and in the aching pains produced by *la grippe* and dengue. It exerts a decided beneficial influence in bronchial and pneumonic troubles, as well as the fever of phthisis.

It acts as an analgesic by obtunding the sensibilities of the vaso-motor and sensory nerves. It seems to tranquilize the ganglionic centers of the whole nervous system, and has but slight action on the brain. We mean by this, that it does not stupify or produce unconsciousness. It seems to have no disturbing influence on the kidneys. It has a happy effect in nearly all neurotic troubles, and is destined to occupy a permanent position in therapeutics.

Antikamnia is of the Amido-Benzole series, in combination, and is much to be preferred to any other of this class of derivatives.

MEMBERSHIP IN THE AMERICAN PHARMACEUTICAL ASSOCIATION is obtained only by election at the annual meeting. "Every pharmacist and druggist of good moral and professional standing, whether in business on his own account, retired from business, or employed by another, and those teachers of pharmacy, chemistry, and botany, who may be especially interested in pharmacy and materia medica," are eligible for membership. For blank application and further information, address Dr. H. M. Whelpley, 2729 Washington avenue, St. Louis, Mo., Chairman of the Committee on Membership.

TASTELESS COD LIVER OIL.—I have used Wampole's Tasteless Preparation of Cod Liver Oil during the past twelve months with much satisfaction, and consider it one of our best and most reliable tonics. It is well borne by the stomach, and can be taken continuously without the unpleasant effects usually following the use of this preparation.

J. C. JOHNSON, M. D., Atlanta, Ga.
(Lecturer on Diseases of Children, Atlanta Medical College.)

DEATH OF SIR MORRELL MACKENZIE.

Sir Morrell MacKenzie, of world-renowned fame, died in London on February 3, of tuberculosis, after a short illness. This distinguished physician was born in Leytonstone, in Essex, in 1837, and was educated at the London Hospital Medical College and in Paris and Vienna. He founded the hospital for diseases of the throat in Golden Square, London, in 1863. In the same year he obtained the Jacksonian prize from the Royal College of Surgeons for his essay on diseases of the larynx. He was soon afterward elected assistant physician to the London Hospital, becoming in due course full physician, and was appointed lecturer on diseases of the throat, an appointment which he held to the time of his death. He was corresponding member of the Imperial Royal Society of Physicians of Vienna, and of the Medical Society of Prague, and an honorary fellow of the American Laryngological Association.

Dr. MacKenzie was the author of numerous publications on laryngological subjects, and in particular of a systematic treatise in two volumes on "Diseases of the Throat and Nose," which is acknowledged to be a standard work, having been translated into French and German, and having a very large circulation in England and America. Dr MacKenzie was also the author of monographs on diphtheria and hay fever, and of an article on "Specialism in Medicine," which appeared in the Fortnightly Review in 1885, and which excited considerable attention. Dr MacKenzie was in attendance on Frederick III, German Emperor, during the latter's illness and was knighted in 1887. He published in 1888 "The Fatal Illness of Frederick the Noble." At the close of that year he resigned his connection with the College of Physicians. In 1889 he contributed to the Contemporary Review, some essays entitled "The Voice in Singing and Speaking."

Sir Morrell MacKenzie had suffered from bronchitis and asthma, following his recent attack of influenza. His illness, however, it was considered, had taken a favorable course. He was attended by his brother. His death was quite sudden. Only his wife was present when it occurred.—*Medical Fortnightly.*

Editorial.

THE PROPER SPHERE OF SURGERY.

While operative measures upon any part of the organism come within the legitimate field of surgery, there are prerequisites in the recognition of the conditions warranting an operation, and in the preparation of the patient for undergoing it, which should characterize the true surgeon. Thus it may turn out that one who is habil, and dexterous in the use of instruments, is not properly qualified for the highest achievements in surgery, from lack of precaution.

The aim of the surgeon is a proper comprehension of the abnormality in all its bearings, and his end should be to afford relief with the least possible impairment of the functions of the part involved.

Meddlesome surgery is the outgrowth of ignorance and inexperience, while masterly inactivity may result from overcaution against doing harm; but the properly qualified surgeon will consider every phase of the case, and assume the responsibility of action or inaction regardless of the criticism of others.

Surgical pathology should not be limited to the macroscopic observation of the changes incident to inflammatory processes, but should include those modifications impressed upon the tissues by neurotic disorders, whether resulting in impairment or undue activity.

Surgical diagnosis should not be confined to what can be seen and felt, nor should surgical practice be circumscribed by the sphere of the knife or the ligature.

While the distinction of internal and external treatment is held by most European authorities to indicate the practice of medicine and surgery, it is not applicable in the broad sense of relegating all the disorders of the inner structures to the practitioner of medicine. Nor should we conclude that all the pathological conditions not calling for operative measures are beyond the domain of surgery. A more fitting basis of recog-

nition for the different spheres of medicine and surgery would be that of functional and organic diseases. With this clear and definite limitation of the province of the physician, as contradistinguished from the field of the surgeon, the work of the former would be confined to such measures as are calculated to correct the functions of the different organs, whether internal or external.

Whenever organic changes ensue, the case then comes within the domain of surgery, whether it demands the use of medicine or a resort to operative measures. It presents conditions of structural modification, more or less developed, which alter the normal constituents so as to produce a change in the size, shape or density of the part involved. It may necessitate an incision or a puncture to diagnose such a state, which, upon being verified, would not warrant a radical operation; but if this change of structure could be clearly ascertained witho t an exploratory operation, it would none the less belong to surgery. With the line drawn between functional and organic disorders for the practitioner of medicine and surgery, so soon as a transition may be observed by the former, the case should be turned over to the latter.

Here lies the practical importance of the distinction submitted for due consideration by all concerned, and if a proper discrimination is made by the physician in the course of his treatment, there will not be so many instances of surgeons being called on to lead a forlorn hope in battling with the latter stages of disorders.

The want of proper investigation of all the symptoms in a case presenting grave complications may induce a physician to delay calling upon a surgeon until the opportunity for relief has passed and his interference would avail nothing.

A timely consultation may arrest such an undesirable result and is earnestly urged upon practitioners J. McF. G.

I have used Peacock's Bromides with marked success in cases of hysteria, cerebral congestion, convulsions, spinal meningitis, and in fact all nervous diseases.

JOHN CROFT, M. D., Detroit, Mich.

THIRTEENTH COMMENCEMENT OF THE SOUTHERN MEDICAL COLLEGE.

The Southern Medical College held its thirteenth annual commencement Thursday afternoon, March 3d, at DeGive's opera house.

During the term ninety-five students were in attendance at the lectures, forty-six of whom were seniors and forty-nine juniors, representing almost all of the Southern States and many of the Northern.

Of the forty-six senior students, thirty-four were presented as entitled to the degree of doctor of medicine. The graduates were as follows: A. Mayfield Allen, South Carolina; William A. Allen, Georgia; Peter M. Baker, Alabama; Thomas B. Bonner, Georgia; William W. Bonner, Alabama; George Brown, Georgia; William J. Cox, Georgia; Alton R. Danforth, Georgia; John H. Garrett, Alabama; Charles J. George, Georgia; Herbert L. Gill, Georgia; William R. Groover, Florida; William T. Friddell, Georgia; Grant P. Fuller, New York; John D. Hall, Alabama; Lewis M. Hobgood, Georgia; Robert M. Hood, Georgia; Morgan M. Howle, Alabama; John W. Jinks, Georgia; William P. Knight, Alabama; D. Pugh Miller, Georgia; William A. Moore, Georgia; Fredrick M. Mullino, Georgia; Calvins Parker, Georgia; John E. Prichard, Georgia; William A. Ross, South Carolina; Christopher R. Rushton, Alabama; W. Marshall Shepherd, Georgia; James R. Smith, Georgia; Reuben C. Stevens, Alabama; Charles L. Tucker, Georgia; Joseph J. Waller, Tennessee; James M. Welch, Alabama; Beauregard Williams, Georgia.

Dr. Joseph J Waller, of Tennessee, took first honor. He is the first man that has ever made a ninety-five out of a possible ninety-six. The first prize was a gold medal.

The second honor man was Dr. W. J. Cox, of Georgia. The second prize was an amputating case.

Dr. Thomas B. Bonner, of Georgia, took third honor, and was awarded a case of pocket instruments.

The following gentlemen were granted honorable mention: Dr. William R. Groover, of Florida; Dr. James M. Welch, of

Alabama; Dr. Christopher R. Rushton, of Alabama; Dr. A. Mayfield Allen, of South Carolina.

After the diplomas had been delivered, Dr. Powell, president of the college, made an able address to the young men which was highly entertaining.

Dr. George Brown, of Georgia, was the valedictorian for the class, and his speech was one that his classmates and those who were fortunate enough to hear, will long remember.

The exercises were closed with an oration by the Rev. Dr. Robbins, annual orator for the occasion.

Dr. William Perrin Nicolson, the dean, gave over the medals, prizes and presents with hearty words of cheer to the class.

The annual banquet was held at Vignaux's, at 8:30 o'clock the same evening, and was a complete success.

Dr. George Brown acted as toastmaster, and in the happiest manner imaginable discharged his duties.

Dr. T. S. Powell, president of the college, responded to the first toast. It was "The New College." Dr. Powell's response was a decided hit.

Dr. G. G. Roy responded to "Therapeutics—Ancient and Modern," and did it in a most captivating style.

Dr. J. McFadden Gaston discoursed upon "Conservatism with Discretion—the Highest Attribute of the Surgeon," and was discreet in his conservative sayings.

"Medical Education" gave the dean, Dr. William Perrin Nicolson, a chance to tell those present many good things.

Dr. W. S. Elkin responded to the toast of "Surgery, Past and Present.

Dr. Charles S. Webb spoke on "My New Diploma."

Dr. C. D. Roy and Dr. L. B. Grandy responded happily to "The Next Generation in Medicine."

"The Dental Department," was Dr. Sid Holland's theme.

"The Law Department," was most happily responded to by Mr. Charles A. Read.

Dr. J. W. Price gave a response to "The Alumni Association of the Southern Medical College."

The evening was closed by the organization of an Alumni Association, with the following officers: Dr. John W. Price, President; Dr. George T. Brown, Vice-President, and Dr. C. Evans Johnson, Secretary and Treasurer.

THIRTY-FOURTH COMMENCEMENT OF THE ATLANTA MEDICAL COLLEGE.

The graduating exercises took place at DeGive's Opera House, and a very large and brilliant audience were present.

The exercises were opened at 8 o'clock with prayer by Rev. James W. Pogue, immediately after which Dr. W. S. Kendrick, proctor of the college, made his report.

The first year's work of the College of Pharmacy was gratifying, and the success has been even more than anticipated.

The number of students during the year was 181, distributed as follows:

From Georgia, 132; Alabama, 11; South Carolina, 8; North Carolina, 6; Texas, 4; Florida, 3; Louisiana, 2; New York, 2; Tennessee, 1; Mississippi, 1; Ohio, 1.

The report showed that this was the largest class in the history of the college. All were pleased with the showing.

Hon. N. J. Hammond, president of the board of trustees, delivered the degrees.

Following is a list of the graduates:

V. H. Taliaferro, Atlanta, first honor; H. W. Terrell, Greenville, Georgia, second honor; J. H. Latimer, Hazlehurst, Georgia, third honor. Honorable mention of Alfred F. Harrington, West Point; T. V. Hubbard, J. F. Yarborough, W. A. Sheldon, S. W. Hart, with the following graduates: M. P. Anthony, H. M. Barton, A. H. Baskin, R. S. Bryan, G. B. Carter J. A. S. Chambers, A. J. Cooper, R. T. Crozier, J. J. Crumbly, Everett Daniel, D. C. Daves, T. N. Dunn, A. L. Franklin, H. A. Gantt, G. M. Gold, J. B. Goldin, W. S. Goldsmith, R. L. Goodbred, J. R. Hall, J. C. Hardy, A. F. Harrington, W. S. Hill, J. W. Hinton, Jr., C. W. Holloway, R. L. Hughes, A. S. Humphreys, J. A. Hutson, J. F. Johnson, W. E. Johnson, Robert Jones, J. A. Kitchens, Lucius Lamar, F. L. Lewis, E. P. Little, R. C. McKown, Thomas McLeod, W. H. Mann, F. J. Mashburn, W. F. May, J. H. Morgan, M. W. Murphy, C. T. Nolan, J. B. Owens, S. B. Patton, G. F. Payne, A. A. Powell, J. F. Reid, E. C. Ripley, W. C. Sessions, W. A. Shelman, C. O. Smith, S. S. Smith, F. V. Turk, W. P. Turk, A. R. Watkins, G. R. Wells, F. L. Wood, D. A. York, J. H. Barr.

Judge Howard Van Epps was orator of the occasion, and made a good speech that was well received.

Dr. J. A. S. Chambers, the valedictorian, made a charming parting address, and received much applause.

Hon. E. W. Martin gracefully delivered the medals to the three honor men, and the exercises were closed.

THE MEDICAL ASSOCIATION OF GEORGIA.

Meets April 20th, 1892.

The approaching meeting of our State Association in Columbus should interest all the profession, and it is hoped that there may be a full representation from the different sections of the State. Many advantages accrue from these annual re-unions of practitioners, and each should contribute his part towards the general fund of information, either by preparing a paper, giving practical observations, or joining in the discussion of subjects at the meeting. But should any one not care to join in the work of writing or discussion, an important service may still be rendered by his presence, to encourage others in performing their duties, and a good listener will reap much profit by attendance. It should not, however, be supposed that a member of the profession who is not a ready writer, or a fluent speaker, is not fitted to present a useful report of his cases, and frequently the observations of this class of practitioners prove highly instructive to his colleagues. Let no one cover his light under a bushel, but come forth with his statement of facts, as viewed from his individual standpoint, thus lending a helping hand in the mutual benefits of comparing the results of experience in the treatment of diseases. There is no preferred class in the medical profession, and all being on an equal footing, each should exercises his right and privilege to present his opinions, so that the truth may prevail in reaching our conclusions.

While the program committee is charged with getting up papers and arranging for their discussion at the meeting, this does not preclude voluntary contributions, and even at the last moment, a report of some instructive case may be made by some one who has not found time to get a paper ready previously. Every member of the medical profession should take pride in promoting the end of the Association, and attend this meeting.

J. McF. G.

A DELIGHTFUL RECEPTION.

One of the most charming receptions ever given in Atlanta, was that to the graduating class of the Southern Medical College, given last night at the residence of Dr. and Mrs. G. G. Roy.

The full faculty, each professor with his lady, was present, and a number of Atlanta's most popular young ladies graced the occasion and added infinite pleasure to the happy young physicians.

Almost one hundred guests were present, and a more pleasant evening was never spent.

Dr. and Mrs. Roy are hospitality itself, and made all feel perfectly at home, in their elegant home. The refreshments were delightful, and the new doctors will never forget the closing evening.

MEDICAL ASSOCIATION OF GEORGIA.

The forty-third annual session of the Medical Association of Georgia will meet in Columbus, Ga., on April 20, 21, 22.

The officers are: President, G W. Mulligan, M. D., of Wasington, Ga.; Vice Presidents, James M. Hull, M. D., of Augusta; Mark H. O'Daniel, M. D., of Macon; Treasurer, E. C. Goodrich, M. D., of Augusta; Secretary, Dan H. Howell, M. D., of Atlanta.

DAN H. HOWELL, M. D.
Secretary Medical Association of Georgia.

DEATH OF DR. CARPENTER. Dr. Alfred Carpenter, of London, author of Carpenter's Human Physiology, died on Jan. 27th.

SIR WILLIAM THOMPSON has been raised to the peerage.

The new crematorium at Heidelberg was used for the first time on December 23d.

MR. BERKLY HILL, Vice-President of the Royal College of Surgeons, England, is dead.

Special Notes.

SANDERS & SONS' EUCALYPTOL EXTRACT (EUCALYPTOL). Whenever mention is made of "Oil of Eucalyptus" we beg you to bear in mind that such reference applies to our preparation, styled for distinction, "Eucalypti Extract (Eucalyptol.)" To avoid disappointment we would suggest to specify, when prescribing, our manufacture. Samples gratis through Dr. Sander, Dillon, Iowa. Meyer Bros. Drug Co., St. Louis, Mo., Sole Agents.

ADVERTISING.—If you wish to advertise anything anywhere at any time write to Geo. P. Rowell & Co., No. 10 Spruce St., New York.

Since I first became acquainted with Terraline (about two years ago) I have used it very extensively and with most satisfactory results. As a remedy for the cough of phthisis, both in early and late stages, I know of nothing equal to it. Combined with creasote (one drop to a teaspoonful) it is extremely valuable since, in this way, we can add to its own nutritive and soothing properties, the antiseptic virtues of the latter drug.

J. EWIN MICHAEL, M. D.,
937 Madison avenue, Baltimore, Md.

I have used your preparation of petroleum called Terraline in quite a number of cases of catarrhal affections of the respiratory organs, and can assure you that it is a most useful and valuable remedy in all such complaints. My experience in general with it has been such as to induce me to recommend it to my professional friends.

Yours truly,
B. SEGNITZ, M. D.,
149 East 63d street, New York.

PEPTONES AND BEEF TEA, (from Ford. Lascar).—One grain pure Papod is dissolved in one ounce of water (two tablespoonfuls), with which are mixed six ounces of raw lean beef chopped fine, the mixture kept for about two hours at a temperature of 130 degrees.

The product is strained through cloth (cheese-cloth), a small quantity of boiled water added, and it is ready for use.

If desired, five per cent. of brandy may be added.

This may also be used as an embrocation when an absorption of nutritious substances is wanted.

Ordinary prepared peptone of beef tea has a bitter taste, which the addition of salts or spices is unable to cover; while this is pleasant and retains the aroma of the beef, it is well suited for rectal alimentation.

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Anæmia from any cause, Struma, latent Syphilis, General Debility. Tuberculosis, Malaria, Loss of Appetite, Habitual Constipation, Chlorosis, Chorea, Chronic Uterine, Pelvic, Zymotic, Catarrhal and Dermatological Diseases.

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Proto-Chloride Ir one eighth grain.

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The Formula will immediately Suggest Itself to the Thoughtful Physician.

DOSE—One or two fluid drachms three or more times a day, as directed by the physician.

This combination of three of the most potent agents at our command, so ma edly facilitates the action of each, that practice confirms the theoretically is an ide Alterative Tonic. Without tendency to derange the stomach or constipate. The physician may add without reservation the soluble salts of Iodine.

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SOLUBLE SUGAR-COATED PILLS.—I have used WILLIAM R. WARNER & Co.'s SUGAR-COATED PILLS for more than fifteen years, and I do not hesitate to say that, in respect to solubility, THEY ARE SUPERIOR TO ANY COATED PILLS I HAVE EVER TRIED, not excepting those coated with gelatine. They possess one quality which I do not find in most other pills, viz: a moist condition of the enclosed ingredients.

ROBERT HUBBARD, M. D.

For the information of those who have to use alcoholic liquors we extract the following from a letter of America's most eminent surgeon and physician, David W. Yandell, of Louisville, Kentucky, written to a medical friend, and used by permission:

"* * * * There are, as you already know, many fine whiskies manufactured in this State under different brands. Among them I may name the BELLE OF NELSON as being thoroughly well made, honest, straight and mellow, and for these reasons being specially fitted as a remedy where alcohol is indicated. Always faithfully yours,

D. W. YANDELL."

I have been much pleased with the action of Febrina Tablets in reducing the temperature of many cases of La Grippe, etc. They are in a pleasant shape, easily taken, and act quickly and I believe more safely than most of the remedies of its class. J. P. CALDWELL, M. D.

U. S. Examining Surgeon for Pensions.

Farmington, Minn.

McARTHUR'S HYPOPHOSPHITE Co.—I received your little pamphlet on the "Curability and Treatment of Phthisis," etc., in November last. It was very interesting, but I had anticipated you in having prescribed, long before, your beautiful Syrup in many cases with effect. It is not only beautiful to the eye but pleasant to the palate. It is certainly the best preparation of the Hypophosphites I have used, and undoubtedly a remedy of great value. R. B. S. HARGIS, M. D.

Pensacola, Fla., Jan. 25, 1887.

DE LAND, FLA., February 1, 1892.

Dear Sirs—In response to your enquiry in reference to the "Elixir of the Three Chlorides," I will say that I have used it in my practice during the last six months, and in all cases to which such a preparation is adapted it leaves nothing to be therapeutically desired. Very respectfully,

D. STUART LYON, M. D.

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Let your motto be **Not How Cheap** are the goods, **B**
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The leading Practitioners recommend long coils for good Therapeutic work:

Of what value are Short Coils?

Our No. 5 Coil contains a length of wire many times than any other apparatus; (except of special construction value) producing currents of great Therapeutic value.

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UR PRIVATE SANITARIUM for the treatment of Medical and Surgical Diseases of Women, will be open for the reception of patients

The building is large and handsome, and was constructed especially for the purpose for ich it is to be used The grounds, about five acres, are beautifully shaded and are very at-ctive. The Rooms are all of good size, thoroughly ventilated, and each has an open grate, ge closet, gas and electric bells, inside and out-side blinds, double hung sash transoms over doors.

The entire Building, except the Surgical Division, is handsomely carpeted and beau-ully furnished. Water closets, with hot and cold baths, on each floor; hot and cold water at ive different places in the halls.

NO WATER PIPES IN BED ROOMS.

e drainage is as near perfect as Sanitary science can make it The house-keeping will be in arge of a most Cultured and Experienced Lady, who is widely known for her excellence and perior merit in this particular. The CUISINE SHALL BE THE VERY BEST, and the service is ry respect as good as it can be made.

A MATERNITY DEPARTMENT, where everything is as near ASEPTIC as possible, and in arge of nurses educated and trained especially for this purpose, is an especial feature of s institution.

THE SURGICAL DEPARTMENT, under same roof but disconnected from the main building, as near ASEPTIC as it can be. We have a full corps of competent Physicians to assist us. esident Physician, with a cottage on the grounds, will be in constant attendance. Our ses are all ladies of education and training in their profession, most of them coming rect from the Woman's Hospital, New York,

Physicians sending us patients may rest assured that they will receive the best care and ention in every particular, and reports will be made every few days. Special rates will be de for the wives and daughters of Physicians and Clergymen.

For further information, terms, etc., address

DRS. HOLMES & DAVIS, Rome, Ga.

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SPERMATORRHŒA.—

In stubborn cases of spermatorrhœa combine ergot with neurosine as in the following formula:

R Fl. ext. ergot, oz. j.
Neurosine, oz. iv.
M. Sig. Teaspoonful in water three times a day and at bedtime.

When a chalybeate or other tonic is desired, together with a nervine, the following will prove eligible:

R Ferri et quinæ ammon cit., dr j.
Neurosine, oz. vi.
M. Sig. Teaspoonful three times daily.

AMENORRHŒA WITH GREAT DEBILITY

Stearnes' cascara aromatic, 1 fl. oz.
Simple elixir, 2 fl. oz.
Fl. ext. of berberis aquifolium 2 fl. oz.
M. Sig. Dose, one-half to one teaspoonful three times a day.

DYSMENORRHŒA WITH HABITUAL CONSTIPATION.—

Stearns' cascara aromatic, 1 fl. oz.
Simple Elixir, 2 fl. oz.
Syr. of Sarsaparilla compound, 1 fl. oz.
Mix. Sig. Tesspoonful three times a day before meals.

JAUNDICE.—

R Hydrarg. cor.chlor. per dose, 1-16 grain.
Potassi chloridi, per dose, 2 grains
Tinct. cinchonæ, 5 ounces.
Tinct. hyoscyami, 3 ounces.
M. Sig. Drachm four times a day.

ANTISEPTIC ADHESIVE OIL.—

R Zinc oxidi, 5 grains.
Zinc chloridi, 20 grains.
Gelatinæ, 5 drachms.
Listerine 7½ drachms. M.

This dressing protects the surface of wounds and dispenses with the use of bandages after operations. It is especially of service for the dressing of wounds on the face.—*Er.*

DISSOLVING DIPHTHERITIC MEMBRANES.—

Caldwell is stated to recommend the following solution for this purpose:

R Papain, 2½ drachms.
Hydronaphthol, 2 grains.
Acid muriatic, 15 drops.
Aquæ destillat, 3 ounces.
Glycerini, 2 drachms.
M. Sig. Apply to the affected parts every half hour by means of an atomizer.—*Medical News.*

THE HOTEL BELMONT,

ASHEVILLE, N. C.,

TO THE PROFESSION:

I have recently moved from the Winyah House to the HOTEL BELMONT, offering now increased advantages in building, location and surroundings.

Special Electric Railway connects the Hotel Belmont with the Railway Station and the City.

Several hundred acres of grounds and parks, sulpher and iron springs are included in the premises.

For particulars, address

KARL VON RUCK, M. D.

Please mention Southern Medical Record.

SUBINVOLUTION OF THE UTERUS.—

Dr. B. C. Hirst suggests the following as the best combination to use:

R Strychninæ sulphatis, gr. 1-20.
Quininæ sulphatis, gr. ij.
Ext. ergotæ, gr. j.

M. Et. ft. pil. No. 1. Sig. At one dose.—*Medical World.*

BRONCAIAL CATARRH.—

R Acetat. scillæ, oz. ss.
Ext. ipecac, f. dr. ss.
Tr. opii deod., dr. j.
Syrup tolu, dr. x.

M. Sig. A teaspoonful every two, three or four hours.—BARTHOLOW.—*Ex.*

For a case of idiopathic epilepsy in a child of three years of age, Dr. Edwin E. Graham said that the treatment by the mixed bromides was the best, and prescribed the following:

R Potassii bromid., gr iij.
Sodii bromid, gr. ij.
Ammonii bromid., gr. j.

M. Sig. Four times a day.—*Ex.*

Professor Pavin recommended to the class the following formula for making a palatable preparation of cod liver oil, which he had found that children would take very readily.

R Olei morrhuæ, f. oz. viij.
Olei gaultheriæ, f. dr. j.
Calcii phosphatis, gr. cclvj.
Pulv. acaciæ.
Sacchari albi, aa oz ij.
Aquæ, q. s. ad Oj. M.
—*Coll. and Clinic.*

PUTRID SORE THROAT.—Late J. Milner Fothergill, M. D., London, England:

R Tr. myrrhæ.
Aceti, aa oz. ij.
Mellis, oz. j.
Infusion serpentaria, O iiss.

M. flat gargarisma.—*Ex.*

GONORRHŒA—

R Chloral hydrat.
Zinc sulph., aa gr. iv.
Aquæ, oz. iv.

Use one-fourth contents of the bottle a. m. and p. m. as an injection.—*Ex.*

As a carminative, the following mixture is excellent:

R Tinct. calumbæ, dr. iij.
Spts. ammon. aromat., dr. iss.
Tr. cardamomi com. q. s. u. f iij oz.

M. Sig Oz. ss. *pro re nata.*—*Ex.*

TERRALINE

A Purified Preparation of CRUDE PETROLEUM for Internal Use.

A Substitute for Cod Liver Oil and Kindred Compounds. An Invaluable Agent in the Treatment of

Phthisis Pulmonalis, Tuberculosis, Catarrh, Cough, Scrofula, Chlorosis, General Debility, Etc.

It promptly allays the extreme pulmonary irritations, improves the appetite and overcomes the indifference and distaste for food, increases the weight of the body and begets a sense of comfort not exhibited by any of the noted remedies given in such cases.

It is put up in plain twelve ounce bottles and is sold only on prescription of the physician, it being strictly confined to the medical profession, by whom it is highly recommended for its therapeutic qualities.

Does not deteriorate with age, as do emulsions of all kinds, but is always fresh and pure, and ready for use.

The dose is small (one or two teaspoonfuls), and therefore it possesses the merit of being inexpensive as well as efficacious, besides is palatable and easy to take, and does not cause eructations or nausea, but is quickly digested by the most delicate stomach.

Here, at the National Capital, it is prescribed by the *entire profession*, with that certainty of result not obtained by any other remedy. By permission we refer to a few of our leading practitioners who use it liberally: Dr. Z. T. Sowers, Dr. James T. Young, Dr. J. O. Stanton, Dr. Byrd Harrison, Dr. Ralph Walsh, Dr. J. P. Murphy, Dr. D. C. Patterson, Dr. H. D. Fry, Dr. D. P. Wolhauptu, Dr. Franzonia, Dr. Sprigg, Dr. Harrison Crook, Dr. Bayne, Dr. Hazen, Dr. Brummell, Dr. Johnson.

R. Terraline. . . . . oz. xii.

Sig, One or two teaspoonfuls three or four times daily, in sherry wine

The price of **TERRALINE** is One Dollar a bottle. A full size bottle for trial will be sent, charges prepaid, to any physician east of the Rocky Mountains, on receipt of fifty cents. Literature on the subject will be mailed free.

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Southern Medical Record.

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. XXII. ATLANTA, GA., APRIL, 1892. No. 4

Original Articles.

MORBID REFLEX NEUROSES.*

BY WILLIS F. WESTMORELAND, M. D.,

Professor of Surgery, Atlanta Medical College, Atlanta, Ga.

When we say *reflex neurosis* we mean nothing; that is a physiological condition. If it were not, you would not have a blush that a person has from any mental impression. I shall speak more particularly of those conditions where there is a *morbid reflex neurosis* where, from irritation at some particular point, you have a morbid reflex trouble. Take, for instance, the eye. As a result of some inequality in the ocular muscles you may have cerebral headache. Oculists go so far as to claim that you have epilepsy or chorea as a result of some inequality of the ocular muscles. Take, again, hypertrophy of the nose; as a result of that you may have acne of the face. As a result of dentition you may have convulsions in the child. All these are amenable to surgical treatment. You operate on the muscles of the eye, and remove the cause of the trouble. By removing the hypertrophy of the nose you relieve the condition. Take a case of asthma where a hypertrophy infringes upon the nasal space, and

*Delivered before the Southern Surgical and Gynæcological Association and reported stenographically for the Southern Medical Record.

by appropriate treatment you remove the cause. I deal with morbid reflex neuroses, as applied to the genito-urinary organs, in the same way.

We have two classes of stricture, viz., organic and spasmodic, or, for the sake of convenience, I will call the latter a functional stricture. It is a condition where there is no organic lesion except it be congenital. In some cases, however, you may have a narrowing of the meatus as a result of chancroid or some condition that will interfere with the space of the meatus. Now, wherever you have a contracted meatus, as a result of it you have a spasmodic stricture, only in those cases, however, where you have had some irritation or the patient is a masturbator. He has had gonorrhœa perhaps; he has had an excessively acid urine; in other words, as soon as there is some irritation of the urethra, no matter what the cause may be, he will have a spasmodic stricture, and as a result of it you have these morbid reflex neuroses. Every organ in the body can be affected.

Dr. Gross pointed out very early in his *Surgical Pathology*, more particularly as applied to women, that the uterus was connected with the stomach, the stomach with the lungs, the lungs with the heart, and the heart with the brain through the nervous system. The genito-urinary organs have the same nerve connections in men, though the morbid reflexes are not so frequent. Now, as a result of this condition, a patient comes to you with numerous symptoms, some of which I want particularly to point out.

A patient will come to you with many symptoms of disease, and you find that he has had no stricture, but owing to the indiscretions of youth he may have been a masturbator, although he has never had any venereal disease. Masturbation in a young subject, who has a large meatus, will not affect him like a boy who has a contracted meatus. As a rule they are born with a small meatus. Where you have a narrowing of the meatus, a man who masturbates or has any irritation will nearly always have a spasm, and as a result of that condition an impression is made upon the nervous system, which causes all of these reflex troubles. I will outline some of them. There is no particular part of the body that is not affect-

ed by these reflexes. It may appear in one patient here and another there. Only after you have seen a number of cases you will find that nearly every portion of the body has been affected. Agreat many patients come into my office and say they have Bright's disease; that they suffer intense pain in the back, have frequent micturition, especially at night. They nearly always have to get up during the night to pass urine. In nearly every one of these cases reaction of urine is normal. They not only frequently urinate at night, but they feel as thoug hthey would like to continue it, the bladder feeling as if it were not emptied of its contents.

Another class of cases come to you with heart trouble. They will say they have a nervous heart, one that is excessive in its action, and they are very much alarmed.

Another class of cases come to you where the trouble is entirely cerebral. They complain of having epileptic convulsions. They have all the phenomena of cerebral headache and inco-ordination; their memory is not as good as it was.

All of these symptoms show that an impression has been made upon the brain and nervous system.

Again, you may have patients—as I have had them—coming to you with four or six convulsions within twenty-four hours. You may have an intermission or continuation of that proportion. I operated on one patient who had on an average, three or four convulsions every three months. You find other patients with acne of the testicles, with an intense itching which is difficult to control. There is really no disease of the skin itself. By continually grasping and rubbing the testicles between the hands the itching is somewhat increased. We find fissure in ano as a result of this form of stricture. In short, we have all of those various troubles, in some patients so marked as to drive them almost to insanity. I have seen patients, who, if they had been put on a witness-stand and tried for insanity, would have been sent to an insane asylum—in fact, the principal physician of an insane asylum told me that he had six cases within the last year or two, in which there was no doubt in his mind but what their troubles were due to this condition. Two of them were relieved by operation. Sometimes you have the whole system affected by it. I had a patient in college who had not walked.

for two years without the aid of crutches. He was confined to his bed part of the time, his condition simply being due to spasmodic stricture. After section of the meatus and the introduction of a full-sized bougie, in three weeks thereafter he walked before the class without crutches. We are too prone to overlook this condition. In cases in which you can pass a No. 23 or 24 sound French scale, you may think the man's urethra is normal; that he has no stricture, and very few symptoms of it. Let me say right here, that one of the worst cases of morbid reflex neurosis I have ever had, was a patient in whose urethra I could introduce a No. 30 acorn sound, and after section of the meatus up to 33 and introducing a bougie of that size, he was relieved of all symptoms. I simply report these cases to impress upon you that a narrowing or contraction of a few millimetres is sometimes sufficient to cause trouble. In this class of patients, the plan I follow is to operate upon them. First to enlarge the meatus, then begin the introduction of a full-sized sound. You have patients come to you who have nightly emissions, perhaps two or three emissions nightly. The mere sight of a woman will cause an emission. Dr. Griggs told me last night of a case he had had, where a man had gone to a circus, and the mere sight of a woman dressed in tights caused him to have a convulsion, and he fell off his seat and came near killing himself. In such cases we should go further than simply treat the spasmodic stricture by the mechanical process of introducing sounds. We should control their thoughts, put them upon hygienic treatment and a good general tonic. In addition to that, if their thoughts are always dwelling upon sexual matters, I generally control them by having them commit a piece of poetry or prose to memory, and by repeating this when these thoughts begin to occur, they control the perversion of the mind toward sexual ideas. Whenever I have patients of this kind I put them in a gymnasium and make them go to work. I do not think there is anything that controls the perversion of the mind like muscular exercise. The fatigue and improved nervous condition in a patient as a result of exercise of this kind, influence very materially the nervous conditions resulting from spasmodic strictures.

An excessive elongation of the prepuce frequently causes this trouble, particularly so if adherent. My experience with club-feet has been, that you rarely ever see trouble in girls. In the majority of cases, you find it in boys, and as a rule, you will find the majority of those boys have trouble with their genito-urinary organs. The boy either has an adherent prepuce, one that is very much contracted, or it is an excessively long one. Some of the worst troubles that have come under my observation was where the prepuce could be retracted but was elongated and very tight, and where all of the nervous symptoms were relieved by the operation of circumcision. In these cases we have other complications. We frequently have varicocele or excessive elongation of the scrotum, and conditions of that kind. You operate on your patient for stricture or perform circumcision and the nervous symptoms are kept up. In two or three cases of this kind I have been able to control them by grappling with this elongation of the scrotum. You will find that a great many of these cases have varicocele or elongation of the scrotum.

In another class of cases, you will find, after you have operated upon them, relief of symptoms for awhile, then the old troubles begin anew. Upon examination of the man's rectum you will find that he has fissure, and when that fissure is stretched you get permanent relief of all symptoms which were not relieved by the operation for stricture.

Another class of cases you have to deal with are cases of fissure in ano. Of course, this is applicable to the female as well as the male. In these cases you have all the reflex neuroses, as a rule, applied to the abdomen in women. You have pain all through the belly; you have constipation; the patient does not have an action of the bowels without taking something to act upon them. A great many cases of chronic constipation are due to fissure which may not be well developed. In speaking of fissure, I would say that fissure is a misnomer; it is nothing more than a spasmodic contraction of the sphincter ani. Patients have the symptoms without the presence of an ulcer. By a fissure, we mean as a rule, we have an ulcer there, and as a result of the irritation produced by it,

you have a spasmodic contraction of the muscles. I want to place myself on record as saying, that in the majority of cases I have seen there has been no ulcer, nor has there been any evidence of its being present in the rectum at the time of examination and operation. They are frequently due to other causes, and those causes are too numerous to mention. I have not time to go into details.

Where you have a spasmodic condition, you frequently establish in the female engorgement of the womb, the trouble perhaps being referred to the vagina or uterus entirely. I have operated on several in the female where the patients had been in the hands of gynecologists for years, and had been treated for uterine trouble. These patients entirely recovered simply by stretching the sphincter muscle. There is one gentleman in the room who has seen some of these cases with me.

I wish to speak now with reference to operations for fissure in ano. A great many physicians recommend the use of speculums for stretching the muscle; while other operators advise you to take a knife and nick the muscle before you stretch it. In olden times surgeons introduced their hands into the rectum, closed their fist and then pulled it out, stretching the muscle in that way. In the use of these different methods you cannot tell how far you stretch the muscle. I have never seen patients lose control of the sphincter as a result of this operation where the fingers or thumb had been used as a method of operation. Incontinence of the feces occurs in those cases where the muscle has been cut, stretched with speculum, or where some of the old methods have been used. My plan is to put the patient under the influence of an anæsthetic. I stretch the sphincter; I feel the contracted parts of it have given way while my patient is under the influence of an anæsthetic; I take my fingers out, and then if there is not any contraction of the muscle—none at all—I let it alone. If the sphincter contracts, it shows that the contracted part is not thoroughly broken up, and I stretch it more while the patient is still under the influence of the anæsthetic.

REMARKS.—I will try and answer the different questions that have been brought out in their regular order: First, in reference to the point made respecting fissure in ano so called. That is one of the principal points that I wish to impress upon your minds. This condition, in my experience, has resulted from other conditions as frequently as it has from an ulcer; in other words, that it is a spasmodic stricture or contracture of the sphincter muscle. I like the word Sayre uses: the distinction between contracted and contractured muscle, and if I may apply this distinction, I should say it was a contracture of the muscle in the majority of cases. Of course, if you had a fissure of the anus the result of an ulcer, it could not be connected with the stricture; it might cause spasmodic stricture; it might be a source of irritation. The point I desire to impress upon you is this: Allingham has said that in the majority of cases fissure in ano is the result of ulceration, a crack or fissure which occurs between the folds of the muscle; that you nearly always have a teat as the result of it. You can run your fingers up behind that teat and find an ulcer above it. In the majority of cases that I have seen there has been no condition of that kind. In a great many instances, you have a spasmodic contraction of the muscle without previously having had an ulcer. When I see a case of this kind, and symptoms of stricture have commenced to appear, before the patient has had any pain or suffered with his bowels, I conclude that it is a reflex which has caused that contraction of the sphincter, and the contraction of the muscle will disappear to a certain extent if you operate on the stricture. I have in one or two cases found a powerful contraction of the muscle where I operated perhaps before the fissure in ano occurred, and the patient got well. The spasmodic contraction had ceased with the improvement of the case.

In reference to elongation of the prepuce causing these troubles, I am sure that it does. When I see a patient with a morbid reflex of this kind, symptoms very much exaggerated, I do not do anything except circumcise him; then the symptoms rapidly disappear. If the patient gets well as a result of the operation, I naturally attribute his trouble to that cause.

I have never done the operation of the Jews, consequently

I do not know of some of them being ruined by their method of circumcision. If I had my way I would circumcise every boy that came into the world. The best time to do circumcision is when they are from one to eighteen months old. I circumcise every child that comes within the ramification of my family practice, and expect to keep it up.

With regard to the point that you frequently find a contracted meatus in men who were circumcised when children, I will say my experience, in the majority of cases, is that where you have a tightly adherent prepuce, you have a contracted meatus, and that in a large proportion of the cases you operate on for that cause you make both operations before the child entirely recovers. You not only circumcise him, but you make section of the meatus. My experience has been in the majority of cases of tight, adherent prepuce, that you nearly always have this contraction of the meatus, and I usually, in these cases, have to do both operations before the patient recovers. I have seen patients who had been circumcised perfectly, yet with all the nervous symptoms they had before the operation. The operation did them no good. Whenever a patient of that kind comes under my observation, I find that he has a contracted meatus as well, and I operate upon it.

These cases are frequently mistaken for organic stricture. Very frequently you will have a patient come to you who is certain that there is organic stricture. In such a case I cut the meatus and the symptoms of organic stricture, caused by sensitive points along the urethra, disappear. If the patient's meatus or urethra will measure No. 32, I cut it to 33. I cut it at least one millimetre larger than the size of the instrument I expect to introduce. I do that for the reason that frequently you have irritation as a result of the operation. In the union of the wound you have a contraction of the fibrous tissue which generally reduces the calibre of the meatus one millimetre. If you cut it to 32 and continue to use a 32 instrument, you have allowed absolutely no room for the contraction of the cicatrix. The result is that while your instrument goes in, you will always have more or less irritation following the introduction—that has been my experience. I have never seen a man cut, no matter to what size, whose urethra

did not close up to the size of the instrument that was introduced. This idea of having cut a man so large that he splatters all over the place is all foolishness. The trouble is the canal closes too rapidly, and we may have to make another section. I have had several cases of this kind. Very frequently I have thought I had an organic stricture, and have promptly cut the meatus, after which I found this contractility which seemed to follow the whole urethra, even the penile portion, has disappeared. After section of the meatus it disappears entirely, and I am enabled to introduce an instrument without any trouble.

Another point. I want to say that my experience is, when a man has cystic trouble as a result of this operation, it is the fault of the surgeon who uses the bougie as a rule; that the irritation comes from the way the bougie was introduced, and does not arise from the fact that the mechanical introduction of it will cause vesical irritation or cystitis as a sequelæ. You have got a very delicate mucous membrane there. When you attack that delicate mucous membrane you should use vaseline on your instrument. There is enough adhesion between the delicate epithelial layers and the bougie, if you carry your instrument in rapidly, to cause disturbance and irritation of the whole canal, especially in the neck of the bladder, where the point that you turn rapidly infringes against the upper portion. Very frequently you have pockets in that portion of the urethra where, if you are not exceedingly careful in introducing it and carry it down with the slightest degree of force, it is enough to set up irritation of that portion of the urethra. I take an instrument, and, if necessary, take five minutes to put it in. When I commenced practice, I introduced my instruments rapidly, and in almost every case in which I introduced it in this way I had either incontinence of urine or considerable irritation; consequently I have since been more careful, and exerted every degree of patience and skill to go slow in introducing the instrument. Then, again, a great many physicians, although they may be careful in the introduction of the instrument, will pull it out with a great flourish, which, in my opinion, causes as much irritation as it does in putting it in. You will find some patients in which a

long curved instrument will not go in without the exertion of considerable force; whereas, by using an Otis instrument, it will go in without trouble, owing to some abnormal outline of the urethra. I frequently see these cases. I keep instruments with different curves. If I have trouble in introducing one, I substitute another, and usually can select one that will go in with comparative ease.

With regard to the point that a contracted meatus is apt to occur as a result of some venereal trouble or lesion, congenital or acquired, I think it very rare. In a practice extending over six years in this particular line, I have only seen two cases. It is unusual for a chancroid or chancre to occur in a meatus, or borders of it, so as to cause contraction as a result of the cicatrix or destruction of tissue. In these cases there were no unpleasant sequelæ, because, as soon as the chancre got well in one case, I cut the meatus to full size. In the other case, where it occurred eight or ten years before, I had all the reflexes you would have from a regular spasmodic stricture.

CLINICAL LECTURE.

BY G. FRANK LYDSTON, M. D., CHICAGO.

Professor of Genito-Urinary Diseases and Syphilology in the College of Physicians and Surgeons.

URTICARIA COMPLICATING SYPHILIS.

Gentlemen—The next case to which I will call your attention this morning, is one which illustrates in a very graphic manner the complexity of some of the problems in diagnosis which occasionally confront the dermatologist. This patient, who is about twenty-five years of age, is as you see very badly nourished, and for excellent reasons. He has been a member of a small theatrical organization which, as he graphically expresses it, "busted a few weeks ago." By industrious counting of railroad ties he managed to reach Chicago, and since he arrived here has eked out a precarious livelihood by doing small jobs of work, and at night has been sleeping in a barn with several other unfortunate histrionic wrecks. His clothing has been scanty, and he has suffered from the extremely cold weather which we have been having,

as well as from lack of proper food. He states that some three months ago he had a chancre, followed in a few weeks by a sore throat and scabs in his scalp with falling of the hair. He states that he did not notice until a few weeks ago any eruption upon his skin. He has several small pimples upon his shoulders, back and breast which he has had ever since he can remember. He has been treated with mercury and iodide of potassium according to his statement since the onset of what was probably syphilis.

About three weeks ago the patient began to be troubled by intense itching of the skin, unattended at that time, he says, by any eruption, which itching was greatly aggravated at night. This has continued until the present time, and within a few days has been greatly increased in severity coincidentally with the appearance of large blotches most marked upon his limbs.

We will now have him remove his clothing and investigate the character of this eruption. You will notice as the most conspicuous dermic lesion, an abundance of crusts formed by dry blood here and there which are quite characteristic of nail scratches. Upon the arms, forearms and thighs will be observed a number of pink and white elevations of irregular form which, he says, itch and burn constantly. On inquiry we find that these lesions appear and disappear in various locations within a very short time. For example, he states that early this morning there were no blotches upon his forearms. The merest tyro would scarcely fail to recognize the character of these lesions. They constitute the typical eruption of urticaria. I notice here and there a faint mottling or pigmentation of the skin which is suspicious of a previous syphilitic lesion. I will now ask the patient to step away to the rear of the amphitheatre and would like you to look steadily at the polymorphous eruption upon his skin. As the patient recedes from you, you will observe that the nail marks and urticarial eruption gradually fade. The same is true of the eruption of papules interspersed with a few pustules to which I will call your attention, upon the shoulders, back and breast. The faint pigmentation of the skin, on the contrary, becomes more prominent as the patient recedes,

see plainly an eruption beneath the skin of the char-
e ham-red color approximating here and there a cop-
e characteristic of fading roseola. The inguinal, epi-
l, and cervical glands are characteristically indurated
arged, and on examination of the mouth and throat
the peculiar congestion of the fauces so familiar in
ry syphilis, and several mucous patches upon the
The hair, you will observe, has fallen out in marked
here and there (alopecia areata). We have here then
ex eruption. In the first place, we have the lesions
d by scratching for the purpose of relieving the in-
eneral pruritis. Secondly, the lesions of acne vul-
Thirdly, those of ordinary urticaria. Fourthly, a
oseola syphilitica.

h to call your attention to the practicality of the
which I have adopted in this case of subtracting, so
k, the element of confusion afforded by the non-spe-
ions from the syphilitic eruption *per se*. The manner
a the syphilitic eruption became more prominent and
-specific eruptions less prominent as the patient re-
om you should certainly be an excellent object les-
he original difficulty in this man was undoubtedly
. As a consequence of privation and exposure to in-
weather, a certain degree of nervous disturbance of
a has resulted with the production of that form of
which, for want of a better term and on account of
istence with the onset of cold weather, we have
winter itch. It is probable that this irritation of the
sociated with that produced by vigorous scratching
eloped the urticaria; there may possibly be some gas-
stinal disturbance as an additional factor.

ine of treatment which should be followed in this
nore simple than practicable. The patient should be
used, fed, and warmly clothed, and should take fre-
arm baths containing starch and carbonate of soda in
. The only remedies suitable for internal medication
ase at the present time are tonics of various kinds.
se is important chiefly from a diagnostic standpoint

and shows how exceedingly careful we must be in dermatological work.

CIRCUMCISION IN A CASE IN WHICH THE OPERATION HAD BEEN PREVIOUSLY IMPROPERLY PERFORMED.

The next patient presents a very interesting condition as showing how a supposedly simple operation can be bungled by a careless and incompetent operator. This boy of twelve years of age has just passed through the hands of a firm of advertising quacks in this city who attempted to perform circumcision upon him. The mother states that he is worse than ever, and has therefore brought him to the clinic this morning to ascertain why he is worse than before the operation, and cannot pass his water as readily as before. Upon inspection of the affected organ you will observe that the prepuce is very tightly drawn forward over the glans and that I cannot retract it even by using considerable force. The preputial orifice presents evidences of the operation which the boy has undergone in the form of a puckered circular cicatrix through the lumen of which I can barely introduce a probe. The cause of this condition is evident. The person who performed the operation simply drew the foreskin forward and snipped it off, after which he allowed the part to heal at its own sweet will. The only thing to do is to rectify the damage done by the previous attendant. We will proceed by splitting up the prepuce upon the dorsum, trimming off the scar tissue, turning back the flaps of mucous membrane and stitching them to the penile integument in the same manner as in a primary circumcision. It is frequently recommended by excellent authorities to omit stitches in the circumcision of children; but I would advise you to always insert them unless some special contra-indication exists. In performing this operation be sure and allow plenty of room for subsequent expansion of this organ. This may be done by making a short longitudinal incision in the proximal flap, *i. e.* in the penile portion of the skin; the corners of skin which are left should be trimmed off with the scissors.

THE TREATMENT OF GALL STONES, WITH CASES.*

BY W. E. B. DAVIS, M. D., ROME, GA.

President of the Tri-State Medical Society of Alabama, Georgia, and Tennessee; Secretary of the Southern Surgical and Gynecological Association, Fellow of the American Association of Obstetricians and Gynecologists; Honorary member of the Medical Society of the State of New York; Formerly member of the Jefferson County (Birmingham) Board of Medical Examiners, etc., etc., etc.

He said:—The treatment during the attacks, consisted in hypodermics of morphine and atropine, with the use of ether and chloroform until the other remedies have had time to take effect. It is usually soothing to place the patient in a hot bath; and large draughts of hot water will relieve the distressing nausea. After gall-stones have formed, experience does not warrant us in placing confidence in medical treatment for their cure. The sweet oil draughts, as has been abundantly shown, only become saponified and give rise to stone-like masses. Turpentine, chloroform and wild yam are not curative. Perhaps something may yet be found that, when injected into the bladder, will dissolve the stones. This is especially desirable for stones located in the ducts.

It would seem that medical treatment would prevent their formation, but so far, there is no very good evidence to show that any medicine has this effect.

A stone in the gall-bladder produces such a condition as to favor the formation of other stones; and after the operation for the removal of the stone, and the relief of the local condition, we have no return of the disease, except in a small per cent. of cases. This is so in those cases in which stones had been forming rapidly before the operation, and would go far to show the importance of the local causes of the disease. Then in addition to general tonics, iron, phosphate of soda, mineral waters, etc., our dependence must be placed on operative procedures.

In some cases it may be difficult, or even impossible, to

(Abstract of a paper read at the fourth annual meeting of the Southern Surgical and Gynecological Association.)

make a diagnosis of gall-stones, but it has been said very correctly that the mistake is much oftener made in calling gall-stones something else than in calling something else gall-stones. Paroxysms of epigastric pain, with tenderness over the lower hepatic region, accompanied with bile in the urine, and followed by clay colored stools, and sometimes the passage of stones, are symptoms on which dependence must be placed. The shoulder pain is rarely present and jaundice is most frequently absent. It is only when there is obstruction in the hepatic or common duct that this symptom is to be expected; and often the obstruction is so evanescent as not to give rise to sufficient obstruction to produce jaundice.

Where there are frequent attacks of biliary colic, it is best to operate and give the patient the benefit of the exploration, and avoid the dangers of peritonitis. It is not conservatism to delay operation where there are obstructive symptoms, until the liver has become involved and the patient's blood poisoned. He had seen a number of these neglected cases in which an operation could afford no chance whatever. He reported a case of death from peritonitis following repeated attacks of biliary colic, where there was sufficient warning to save the patient, but her physician would not advise an operation. In some cases, however, there are no symptoms to indicate the presence of a stone, until peritonitis has resulted from ulceration thus induced. During the past month he had operated on such a case at Asheville, Ala., for Dr. D. E. Cason. The patient was 74 years of age and had never experienced any symptoms of gall-stones. He recommends cholecystotomy, and opens the bladder and sutures it to the parietes at one operation. He reported a case in which he removed 51 gall-stones from the bladder, one of them being impacted in the cystic duct, and the patient made a perfect recovery.

Cholecystectomy, the removal of the gall-bladder, should never be an operation of selection and only resorted to when cholecystotomy is not possible. Do not stitch the bladder to the parietes and wait for adhesion before opening the viscus, as it is necessary for it to be opened and emptied before the abdominal wound is closed, in order to recognize conditions

which will require manipulations within the abdomen as well as within the bladder. Stones impacted in the duct must be dislodged and pushed into the bladder or duodenum. It may be necessary to break them up with a needle before this is possible. In some cases the duct should be incised and sutured. When the obstruction in the common duct cannot be relieved, cholecysto-enterostomy should be resorted to.

MALARIAL HÆMOGLOBINURIA.

BY H. E. WILLIAMS, M. D., FORDYCE, ARKANSAS.

I have been watching with particular interest numerous articles relative to hæmoglobinuria and its treatment, and appearing in different medical journals of recent date.

There seems to be much difference of opinion with physicians as to treatment, also as to the pathological condition that exists. I have had considerable experience with this fearful malady, having practiced medicine in the Mississippi swamps for ten years, and treating a great many cases each year, I have consequently seen it in every form, from the mildest to the severest.

As I have been solicited by some medical friends to offer for publication my plan of treatment, it will become necessary that I give my views as to the etiology and pathology in order to arrive at a correct basis for treatment.

We are all agreed that this disease is dependent upon malarial bacteria—those minute organisms being developed in a low marshy country, by high temperature, decomposition of vegetable matter, and stagnant water. These germs being developed, find their way into the human body by way of the digestive and respiratory organs, and the cutaneous surface; hence,as the disease is due to these germs, we must class it with the zymotic affections. The bacteria, after entering the circulation, produce more or less destruction of the blood plasma, and the fibrinogen of the red blood corpuscles (from zymosis) ; the red corpuscles, being set free in a state of disintegration, liberate its coloring matter (hæmoglobin). Now, as the red corpuscles are in a state of disintegration, they can no

longer act as oxygen-bearers; consequently, this mass of broken down blood becomes effete matter. The coloring matter being set free, finds its way by general extravasation throughout the entire body. Nature now makes an effort to eliminate this effete matter by way of all the emunctories of the body; hence the bloody colored urine, rapid jaundice, black vomit. By way of digression, I will here state that the jaundiced condition is not (as was formerly supposed) due to extravasation of bile, but is due to diffusion throughout the body of this disintegrated blood, or coloring matter. As proof of this, I have often witnessed, after the application of a blister, a bloody-colored fluid in the vesicles, instead of the characteristic yellow fluid usually found in blisters.

Hæmoglobinuria attacks those who have been suffering with chronic malaria and chills. It is ushered in with a pronounced chill, followed by high fever, thirst and vomiting, rapid pulse, tongue usually coated with a heavy brown coat, headache, pain in lumbar region, rapid jaundice, bloody-colored urine; in the course of two or three hours a slight defervescence occurs, the skin begins to act, and the patient expresses himself as feeling better; but soon after a rigor occurs, with a rapid rise of temperature, with all the former symptoms more aggravated.

If left alone, these rigors occur about every four or five hours, each one rendering the case more grave, until finally black vomit, uræmic convulsions, or coma, with suppression of urine develops, and the case soon terminates fatally.

Now, how are we to treat a case like this? Medical men unacquainted with this formidable disease would very naturally suggest that, as this is one of the malarial affections, that we use quinine, it being considered a panacea in malaria; but from ten years' experience with this disease, I was forced to the conclusion that the use of it was not only a mistake, but a very grave one, I never having seen a case recover where quinine was used, even moderately.

There are certain conditions present in this disease that will not admit of the use of quinine, namely, high arterial pressure, deficient oxygenation of blood, due to destruction of red

cells, defective elimination of urea, together with other products of waste, and a tendency to suppression of urine.

We are all aware that quinine, even in medium doses, diminishes the secretions of skin, gastro-intestinal and renal—the very conditions we don't want present. H. C. Wood's Materia Medica, edition of 1881, page 74, says: Ranke noticed that quiniæ lessened elimination of uric acid, also the other constituents of the urine. Zuntz found that twenty-five grains of quiniæ reduced his elimination of urea nearly 40 per cent.

Now, why should we persist in the use of quinine in this disease, when we see the effects are inimical to the conditions we have to combat? We augment the defective elimination of urea that already exists; dry up the renal secretion and hasten uremic coma, and I might add, kill our patient, for I do think a patient has hardly one chance in a thousand to recover if under the care of a physician using quinine.

Since abandoning quinine, my treatment has been to give an active mercurial course to arouse the alimentary tract.

℞ Hydrarg. chlo. mit., gr. xv.
Ipecac pulv., gr. iii.
M. ft. chartes No. 3.
Sig.: One powder every three hours.

As an antiseptic, I have used with excellent results, antipyrine, guarding the action of the heart with digitalis, if necessary, say—

℞ Antipyrine, ʒ ss.
Ft. chartes No. 5.

Sig.: One every three hours until fever subsides; after which I give eucalyptol in ten drop doses every three hours in capsules. I have found it to be a good antiperiodic, and a fine reconstructive agent, as well as a germicide.

From the beginning, I use sulphite of soda for its antizymotic action, and carry it to the point of saturation as early as possible.

I never meddle with the kidneys unless they begin to suspend action, or the flow so excessive as to threaten life by exhaustion. If the kidneys begin to fail, I use

℞ Tr. digitalis, ʒ iv.
Potass. nitr., ʒ iv.
Fl. ex. scoparin, ʒ vi.
Aqua, q. s., ℥ iii.
M. Sig.: Teaspoonful every 3 hours.

In addition to this, I usually flush the colon with warm water from time to time for its revulsive effect on the kidneys. I make no effort to check the so-called hæmorrhage, for I consider it an effort of nature to relieve itself of this effete matter, and should not be checked.

When convalescence is established, the patient will need a tonic. I have found this to act nicely:

℞ Tr. ferri chlo. ʒ vi.
Acid phos. dil., ʒ iv.
Tr. nucis vom., ʒ v.
Aqua, q. s., ℥ iv.
M. Sig.: Teaspoonful three times daily, after meals.

Since adopting the above plan of treatment in this disease, I have lost very few cases, and all of them, when I used quinine

HOW TO ADMINISTER IRON.

It is generally conceded that the officinal tincture of chloride of iron is the most valuable of the iron preparations therapeutically. The practical difficulties attending its administration for a length of time have been its disagreeably astringent taste, its corrosive action on the teeth, and its constipating action.

Dr. G. W. Weld's extensive experience in the practice of dentistry led him to recognize the virtues of the tincture of chloride of iron as a stimulant resource for patients after the strains of the dentist's work. Repeated experiments to obtain a formula free from the objectionable features resulted in the preparation of a highly palatable syrup with all the therapeutic efficacy preserved. This has been extensively tested and placed in the hands of Parke, Davis & Co. for manufacture, who strongly commend it to the medical profession for trial. Being prepared after Dr. Weld's formula, it is entitled Weld's Syrup of Iron Chloride (P., D. & Co.'s). It is believed it will effect a revolution in iron administration.

Society Notes.

ATLANTA SOCIETY OF MEDICINE.

MEETING OF MARCH 1ST, 1892.

President W. S. Kendrick in the chair.

DR. INGHRAM reported his experience with apomorphia. A young lady 25 or 30 years old, drunk, hysterical and hard to control. Gave her apomorphia, 1-10 gr. hypodermatically. Patient vomited freely, relaxed and rested quietly. A well-known business man took a large dose of bromidia, and became violently insane; required three men to control him; tried to kill himself and others. Gave 1-10 gr. of apomorphia. He soon vomited, bowels moved, relaxed, and relieved mental condition. Slept well remainder of night. I have used apomorphia in one case of epilepsy—woman aged 40, cataleptic. It acted well. Have used it in bilious colic. An Irishman had a very severe attack; gave 1-10 gr., which caused him to vomit about one gallon of partially digested food, with marked relief. Used it in one case of eclampsia without effect. Patient died about one week afterward. In alcoholism it vomits patient freely. Have used it also in whooping cough to relax spasmodic attacks.

DR. DUNCAN—At 4 a. m. this morning was called to a case of labor. Found patient up; waters had escaped, os dilatable but not dilated fully. I soon dilated os, but head would not engage in pelvis. It was a natural vertex presentation, head not unusually large. Passing finger up posteriorly, found a body just back of head, which was slightly movable between pains. Waited 2 1-2 hours, then applied forceps and delivered. Upon further examination, found another child, feet presenting, which was soon delivered.

He also reported a case of meningitis, 16 years old, colored male. It was reported to be a case of pneumonia. Called last Saturday, and found a case of meningitis, with cervical glands enlarged, opisthotonous and a syphilitic element to deal with.

Gave usual treatment for meningitis. Patient died in three days.

DR. WILLIS WESTMORELAND reported two cases of tracheotomy for foreign bodies. One, a girl of 8 years, swallowed a piece of knitting needle bent in shape of a hair pin. Cut down and found it without much difficulty. The second swallowed a cocklebur four days previously. Performed tracheotomy. Could not find the foreign body; cut two more rings of trachea; kept wound open and the cocklebur came out four days after operation. Left wound open, but did not use tracheotomy tubes; simply attached silk thread on each side of wound in place of tube, which acts better, allows better opportunity for escape of foreign body and no tube left in to irritate parts. Both cases recovered.

DR. KIME reported a case as follows: Was called February 9th to attend Mrs. A., age 23 years, in first confinement. Arrived at 6 a. m. to find child born, cord severed. Removed placenta without any difficulty, which looked to be complete. She was taken at 2 a. m.; in labor four hours. There was a slight laceration of perineum, but did not deem it sufficient to demand sutures. On second day after labor, noticed a slight elevation of pulse, which increased gradually five to eight beats a day until the evening of the sixth day, when she had the first elevation of temperature, 99 3-5 deg. Pulse reached 116 next day, with a temperature of 100 deg. F. On evening of the sixth day I examined patient and found uterus anteverted and os contracted, both interfering with drainage and entering uterine cavity. The evening being dark, I simply dilated cervix and irrigated uterine cavity with $HgCl_2$, 1 to 2,000. Next morning I again dilated cervix, disinfected uterine cavity, and curetted, removing some small placental fragments with free hemorrhage. Again irrigated, following with tincture iodine injected into uterine cavity. Irrigated uterine cavity that evening and twice next day, introducing suppositories containing iodoform, 10 gr.; boric acid, 15 gr. The temperature reached 100 3-5 deg. p. m., after which it gradually subsided as follows: February 18th, 100 1-5 deg.; 19th, 99 4-5; 20th, 99 deg.; 21st, 98 4-5. The intra-uterine irrigations once a day were then discontinued, keeping up hot water vaginal

irrigations twice each day with $HgCl_2$, 1 to 2,000, preceded and followed by plain hot water irrigations. Lochia ceased entirely, patient sitting up all day. On February 27th, the 18th day after confinement, temperature again reached 100 3-5 deg. Found uterus anteverted, internal os firmly contracted. On dilating it, two or three tablespoonsful of bloody, purulent, fœtid discharge escaped. Disinfected with mercuric chloride irrigation, hot water and tincture iodine. The next day temperature about the same. Curetted again and irrigated, removing also some small pieces of structure with curette forceps, which seemed too firm for the uterine structures; entirely so for placental structures. With it, also, by use of curette, some shreds of tissue came away resembling partially decomposed uterine mucous membrane. Uterus about 3 3-4 or 4 inches in depth after curetting. Applied pure carbolic acid thoroughly to interior of uterus. Tried to pack uterine cavity with iodoform gauze, but parts were so excessively tender, position of the uterus and contracted os such as to forbid. Next day temperature 99 2-5 deg., highest pulse rate 92. Since then have irrigated uterine cavity twice a day and applied camphor-phenique thoroughly to interior of uterus. Last night, the 21st day after confinement, temperature 99 1-5, pulse, 90.

REMARKS.—For the first eight or ten days after labor, except first, I gave her ergot, then discontinued it, until three days ago I commenced it again. She has taken tonics, quinine and good nourishment. Appetite good, food digests well; bowels require a slight laxative—salines usually given. Feels well and wants to get up all the time. No chills, tongue slightly furred, no pain. No secondary deposits from inflammation, so far as I was able to detect, unless a small place at base of left broad ligament. Every time cervix is dilated, or anything done in uterine cavity, have considerable bleeding. From history of case, quick labor, want of contraction of body of uterus, with contracted cervix, free bleeding on dilatation or entering cavity of uterus, and character of material removed by curette and curette forceps, I am inclined to believe there is a local hyperplasia of uterine muscular tissue or small fibroma of uterine wall. She has always suffered severely at her

menstrual periods, wasting more at flows for the last year or two. First flow at 14 years, then missed two years. Tried various physicians to no good, then used copperas, one teaspoonful, brown sugar, one teaspoonful, to one pint of water, taking one tablespoonful three times a day, which established flow. One can easily understand how a deposit of this character would interfere with contractions of the body of the uterus, while the circular fibres of the internal os would be firmly contracted, preventing drainage. It has been said "a septic uterus is a relaxed uterus and patulous os." In this case we have a contracted os of a uterus containing putrid material, and more properly classed as putrid infection.

C. D. ROY, M. D., Secretary.

R. R. KIME, M. D., Reporter.

CLINICAL SOCIETY OF MARYLAND.

BALTIMORE, February 5, 1892.

The 261st regular meeting of the society was called to order by the president, Dr. Robert W. Johnson.

DR. W. B. PLATT read a paper on "Free Dispensaries, or the Physician and the Poor." Dr. Platt, in his dispensary work, adopts, as nearly as possible, the following plan: Inhabitants of certain squalid alleys, well known to him, are treated without question. The destitute and forlorn, whose aspect is unmistakable to one having dealings with the poor, come in first of all for treatment. Mechanics, artisans or laborers, out of work and out of money, and the poor families of drunken and worthless men, are all entitled to free treatment. Adults who have to pay for their board and lodging out of wages less than $5 per week, are treated free. House servants, earning $10 and $12 per month, can and do pay physicians for advice.

DR. I. E. ATKINSON said: This subject, as Dr. Platt has pointed out, bears upon the patients, the physician in attendance and the profession at large. The abuses of dispensaries is a world-wide complaint, and the difficulties that stand in the way of correcting them are almost insuperable. In the first place, the presence of a person at the dispensary is a confes-

sion of poverty, and when questioned in regard to their financial condition, nearly every patient is prepared to say that he is unable to pay the fees of a physician. Occasionally one encounters patients who, when questioned, avow their ability to pay, and are properly excluded.

I think that the evils of dispensary service are more apt to be developed in dispensaries other than those in which patients are used for clinical purposes. The presentation before a class of students is, to persons who are not degraded, a very disagreeable procedure, and they will refuse to come again unless compelled by necessity.

What kind of patients are entitled to relief? Every one admits that the pauper is a proper person. There is not so much unanimity of opinion with regard to the relief of those persons who are brought to that condition by their own vices. Never mind what his faults nor what his vices, nor how utterly beyond the pale of ordinary sympathy he is, as soon as he is sick he becomes a worthy object of charity. In this way medical charity differs from almost every other kind of charity.

Dr. Platt mentions another class that especially appeals to my sympathy, viz.: the wage-earner who makes $10 per month. As to whether or not he shall pay, depends entirely upon how much he is called upon to pay. A fee of $1.00 would be 10 per cent. of his income for the month, and his medicine would perhaps cost 5 per cent. more. It may be that he should not be the beneficiary of a free dispensary, but of a provident dispensary—the absence of which, in Baltimore, I very much regret. I further believe that the man who earns $1.00 or $1.50 per day and supports his family is entitled to a modified relief. This man, by careful economy, is able to keep his family alive, but he cannot support them in comfort. Just as soon as a member of his family falls sick, his expenditures are enormously increased, while his income remains the same, or is diminished. If he himself falls sick, the income stops, while expenses increase. I think that one of the great needs is that modified form of charity, which we recognize as a provident dispensary. This idea of a provident dispensary is not a new one. The individual pays into it so much per month, and his

membership entitles him to receive the services of good, intelligent physicians, who are properly paid for their services by the association, and gets his medicines at a reduced rate. Membership in the dispensary is only granted to those who receive a certain maximum of wages. Such dispensaries have been in existence in England for fifty years, yet the number is small. The justice of them, the propriety of them and the benefits to be derived from them are so manifest that it is difficult to understand why it is that such a limited popularity should be accorded to them.

That there is dreadful abuse in dispensary practice I am convinced; but that the abuse is not altogether on the part of the patients, I am also convinced. There are few ordinary day laborers who feel able to pay the full fees of physicians and the prices of the pharmacist. Some do it from pride, some from principle, and some they know not why. But in case of continued sickness it is absolutely impossible for them to pay physicians' fees, and they are forced into increasing debts which they know they cannot pay. I am an advocate of that form of relief which shall not pauperize the individual, but will enable him to secure for himself and family proper professional advice and necessary medicines without too great a strain on his purse.

DR. PLATT: I think Dr. Atkinson's point in regard to there being less abuse in dispensaries where patients are used for clinical material is well taken; and yet the great howl that has gone up recently has been on account of a dispensary which is used almost exclusively for purposes of instruction. I think there are many persons who are perfectly shameless about getting charity. There is generally a look about a person who lives poorly and miserably that enables you to spot them as quickly as you can tell a wharf rat from a common one. They have poverty written all over them. There is a middle class, whose earnings are not much, yet who have deposits in the savings bank, and ought to pay. There are physicians who would make a reasonable number of visits at half price, and they can get reduced rates at the pharmacists. As to having patients pay at a dispensary, that has been tried. The only thing that has not been tried thoroughly is to carefully inves-

tigate each patient by a visit to his home. I have had people come to me at the dispensary who owned houses and had bank accounts; others with a large number of children, all receiving good salaries.

I think the key to the whole matter is to look up each individual, and see whether or not he can pay. I think there are very few physicians in this room who charge all persons alike. If a patient cannot pay my full fee, I treat him for less.

DR. HERBERT HARLAN: I have had experience with different dispensaries ever since my student days. I believe that at the dispensary of the Maryland University, where patients are used for clinical purposes, there is very little imposition. It may be on account of the large class of students, for the tendency of people is not to go before a class of students. I have known a good many patients to go to that dispensary on other days of the week, and to absent themselves on the days of the clinic. There is, however, quite a large class of people who like to hear their cases discussed. The Baltimore General Dispensary is not imposed on much, because the physicians visit the patients' houses and see whether they can pay or not. The great abuse is undoubtedly in the special dispensaries. We have tried a good many devices to prevent those who ought to pay from receiving services free. One was for the physician to question them as to their ability to pay. Sometimes they answer yes, sometimes no. Some say they can pay, but others who can pay are treated free. Here is the point that I want especially to raise here: At a special dispensary it is a daily occurrence for patients to say, "Dr. So and So, my family physician, sent me here to have my case treated." Physicians themselves are not as particular about these things as they might be. We ask such people if they pay their family physicians, and they reply, "Certainly we do." Then we refuse to treat them. We have tried in another way to prevent abuse, viz.: by having a clergyman, who is regularly employed for the purpose, to go about the waiting-room and question the patients, and act as judge as to who shall or shall not be treated. This, I think, is a move in the right direction. We are indebted to Dr. Platt for calling our attention to this mat-

ter, and we ought all to make an effort to do away with the abuses.

DR I. E. ATKINSON: The physician who charges but small fees knows that in many cases his patient cannot pay the fees of a special practitioner. I frequently have had patients who pay me go to a special dispensary. They do not ask my opinion about it. They say they cannot pay specialists' fees. I think the standard in regard to this class of patients should be a little different from that of the class going to the general dispensaries.

DR. J. EDWIN MICHAEL read "A Report of Eight Additional Cases of External Perineal Urethrotomy without a Guide"—these cases being in addition to nine cases already reported by him in the spring of 1887.

DR. PLATT thought that, considering the difficult nature of the operation, the success of Dr. Michael was astonishing and very unusual.

DR. ROBERT W. JOHNSON spoke on "A Convenient and Comprehensive Method of Instrument Disinfection," and exhibited the apparatus which he devised and used. Dr. Johnson boils everything except himself, his patient, and the rubber tissue. He boils ligatures, instruments, needles, gauze, etc., and also the trays which hold them. The boiler is a plain tin one, large enough to accommodate the trays, with spigot attached near the bottom. A nest of elongated trays of granite ware is found most convenient. Before leaving his office, he goes over the instruments that will be required and puts them in a tray. The dressings to be used are put in another tray, and so on and finally the trays are built up one upon another, and all are put into the boiler, which is put in the back of the wagon. At the patient's house the boiler is filled up with boiling water, put upon the stove and boiled for twenty to thirty minutes, while the patient is being prepared for operation. When ready for operation, the trays are lifted out by means of sterilized button-hooks. The boiler is put in an elevated position, a rubber tube attached to the spigot, and the boiled water is used for irrigation. It makes no difference whether knives or dressings touch the sides of the trays, for they are quite aseptic.

DR. HERBERT HARLAN asked what means were taken to pre-

vent the rusting of instruments in boiling. He had noticed the curious phenomenon that the steel blades of a set of knives with aluminum handles rusted more readily than those of knives with ivory handles.

DR. CHUNN asked Dr. Johnson's method of preparing his hands for operation.

DR. JOHNSON: By adding a slight amount of bicarbonate of soda to the water, rusting of instruments during boiling is prevented. I sometimes use bichloride on my hands, and sometimes potassium permanganate, cleaning it off with oxalic acid. The latter is probably the best method.

VULVITIS AND VULVO-VAGINITIS IN YOUNG GIRLS.

Comby has seen 150 cases of vulvitis and vulvo-vaginitis in girls varying in age from a few months to thirteen years. By far the most frequent cause is contagion, not produced so frequently as is usually stated by attempted coitus, but by the child sleeping with a person suffering from gonorrhœa, or by using the same articles of toilet. The writer states that he has known cases to occur from the child being bathed in the water of a bath previously used by a person having gonorrhœa. Mechanical irritation, such as that caused by masturbation and oxyluria, is rarely the cause, while one of the eruptive fevers, typhoid, eczema or impetigo, may originate the trouble.

Prophylactic measures consist in avoidance of contact with those suffering from gonorrhœa, and, in institutions, thorough cleanliness in regard to urinals, towels, etc. There is both an acute and chronic variety, the former yielding readily to treatment, while the latter requires vigorous measures. The treatment consists in washing the parts two or three times daily with a bichloride solution of the strength of 1 to 2,000, or of acid boracic solution 1 to 25, with the after-application of powdered salol. Sulphur baths are to be used three or four times weekly. In the case of vaginitis, antiseptic crayons, 1-8 inch in diameter, consisting of cocoa-butter, 15 grains, and salol, 1½ grains, are to be introduced into the opening in the hymen every two or three days.—*Rev. Mensuelle des Maladies de L'enfance*, January, 1892—*Annals of Gynæcology.*

BOOK REVIEWS.

A PRACTICAL TREATISE ON DISEASES OF WOMEN.—By T. Gaillard Thomas, M. D., L. L. D., and Paul F. Munde, M. D. Published by Lea Brothers & Company, Philadelphia.

This work, formerly edited by Dr. Thomas, has been revised and brought up to date by Dr. Munde, incorporating some of his individual opinions, developed from a ripe clinical experience, thereby adding to the value of the book.

The reviser has retained the original peculiar manner of the author, in writing the work, which renders the subjects treated of more easily understood and comprehended by the student.

It presents a conservative view of pelvic inflammations, with the latest methods of treatment, and advises the saline method of after treatment of laparotomy, in preference to the opium plan of treatment.

The plate portraying the normal topography of the female genital organs is an advance over similar works, and comes nearer portraying the normal relation of the parts.

The flap splitting method of operating on the perineum is well presented, while the Emmet operation is not so well presented, including plate XC; page 205.

The work certainly will be a conservative guide to the student, a good counsellor to the practitioner and of benefit to the specialist. R. R. K.

QUIZ COMPENDS.—Physiology, by Dr. Brubake. Published by P. Blakiston, Son & Co., Philadelphia.

This compend on physiology is now issued as the the sixth edition of the work, which is an evidence of its popularity among students and practitioners. It is often impossible for practitioners of medicine to read thoroughly an extended treatise on various subjects, in order to be posted on the very latest advances in medicine, and for this reason, late editions of compends are of great value as such. This last edition is very thorough and complete. C. D. R.

ANNUAL OF THE UNIVERSAL MEDICAL SCIENCES.—Edited by Charles E. Sajous, M. D., and Twenty Associate Editors. Five Volumes. Illustrated. Phila: F. A. Davis. 1891.

The fourth year of the "Annual" finds the work but little changed from the preceding year so far as the order and arrangement of its contents are concerned, which goes to show that the work has approached closely to perfection in these respects. It would indeed be difficult to suggest any improvement.

The work has maintained the high standard originally set for it, and the labor expended upon it has been done for the most part by the same able corps of editors who have made the previous issues so successful. The frequency with which the "Annual" is referred to in current medical literature is the best possible commentary upon its appreciation and success.

Each department is compiled with great care, and increase of uniformity and improvement can be observed on every side, due to the increased practice and unceasing pains of the editors. As a whole, it is well designed, well executed, well illustrated, and so arranged as to be readily available to every person who desires to know of the work done in any field of medicine during the past year.

SAUNDERS' POCKET MEDICAL FORMULARY, with an appendix containing Posological Table; Formulæ and Doses for Hypodermic Medication; Poisons and their Antidotes; Diameters of the Female Pelvis and Fetal Head; Diet List for Various Diseases; Obstetrical Table; Materials and Drugs used in Antiseptic Surgery, etc. By William N Powell, M. D., author of "Essentials of Diseases of Children," one of the associate editors of the "Annual of the Universal Medical Sciences," Chief of the Medical Clinic of the Philadelphia Polyclinic. W. B. Saunders, publisher, 913 Walnut street, Philadelphia, Pa. Price $1.75 net, buckskin; $1.50 net, cloth.

This little book contains a great number of valuable prescriptions, new and old, with blank leaves for additional formulæ by the possessor.

We can recommend it to busy practitioners, as a most valuable one. D. H. H.

INTERNATIONAL CLINICS.—Edited by John M. Keating, M. D., J. P. Crozer Griffieth, M. D., J. Mitchell Bruce, M. D., F. R. C. P., David W. Finlay, M. D., F. R. C. P. Published by J. B. Lippincott Co., Philadelphia.

Volume III. of this work shows with what careful selection and arduous labor it has been compiled, and altogether fully maintains that degree of excellence which has hitherto characterized those volumes preceding it.

Beginning as it did by way of experiment, it has from the first, met with universal favor, and to-day occupies a conspicuous place in the library of nearly every progressive man in the profession.

For those which are to follow, we bespeak a success as unprecedented as that of its predecessors.

C. E. J.

SOLUTION OF BROMIDE OF STRONTIUM.

(PARAF-JAVAL)

This neutral and permanent *Solution of Bromide of Strontium* (*Paraf-Javal*) is a perfectly reliable preparation for dispensing purposes, containing 60 grains of the pure salt to the fluid ounce, or 30 grains in each tablespoonful.

The indications are those of Bromide of Potassium, in such nervous affections as epilepsy, hysteria, asthma, St. Vitus' dance or chorea, paralysis with involuntary agitation, nervous conditions in spermatorrhœa and Plomber's colic, of which it relieves the most violent pains.

In diseases of the chest, it prevents the vomiting, relieves the cough which is so fatiguing in these troubles, besides the system is benefited by the general stimulant effect on the nutritive functions, which characterize the Strontium salts (Paraf-Javal).

In Diabetes, its action on the nervous system, causes a diminution in the amount of sugar excreted.

The normal dose is from 4 to 6 tablespoonsful daily, to be taken before meals; larger doses may however be given if judged necessary by the medical practitioner.

The absolute purity of the Bromide of Strontium and its solution, are guaranteed by the fac-simile signatures of Paraf-Javal and Chapoteaut upon the labels.

Selections and Abstracts.

PURE STRONTIUM SALTS.
(PARAF-JAVAL)

These salts, from which every trace of Barium has been removed, are those with which the very successful investigations were originally carried out at the Paris Hospitals and which alone are mentioned in the communications read before the French Academy of Medicine and other learned Societies.

There has always been a vaguely expressed, but generally accepted opinion, that Strontium salts participate in the poisonous properties of Barium, on account of the close approximation which the two metals hold in their chemical position to the other elements.

The new and precise investigations however of Dr. Laborde, *chef des Travaux physiologiques a la Faculte de Medecine de Paris*, have put an end to this legend; the communications made by this *savant* to the French Academy of Medicine (1) and to the Society of Biology, have established once and for all, that far from being harmful, pure Strontium salts (Paraf-Javal) have on the contrary a favorable influence on the phenomena of nutrition.

The same authority showed that the previous contradictions and errors on the subject of the toxic effects of the Strontium salts were due exclusively to the greater or less impurity of the commercial products used, containing small amounts of baryta.

Professor Germain See in affirming the absolute innocuousness and remarkable therapeutical action of the Strontium salts, (Paraf-Javal) in certain maladies, mentions the fact that they were already the subject of an inaugural thesis inspired by the late Professor Vulpian in 1885 (1).

(1) Academie de Medecine de Paris (Seances du 21 et 28 Juillet 1891.)

(1) Academie de Medecine (28 Juillet 1885).

Drs. Constantin Paul and Dujardin-Beaumetz are not less positive of the merits of the Strontium salts, (Paraf-Javal) (2).

Dr. Constantin Paul, referring to his experiments, says:—"I gave 6 grammes daily of Bromide of Strontium (Paraf-Javal) to a young girl suffering from hysterical epilepsy, for two months.

"The attacks had hitherto returned periodically before the menses and resisted the regular daily administration of 4 grammes of Bromide of Potassium.

"The Bromide of Strontium (Paraf-Javal) appears to have prevented the attacks, for they have not since recurred."

Dr. Dujardin-Beaumetz found that Bromide of Strontium (Paraf-Javal) possesses the indisputable advantage of being better borne by the stomach than the other alkaline bromides.

The important position occupied by Bromide of Potassium in the treatment of nervous diseases is well known, but unfortunately, if administered for any length of time, it provokes intolerance, which, in addition to a disturbance of general nutrition, gives rise to symptoms of intestinal septicæmia, followed by cutaneous eruptions associated with intense depression and cerebral torpor.

It is therefore eminently desirable to find a substitute, a succedaneum, to use a therapeutical term, for Bromide of Potassium, a drug in fact which shall possess all its advantages without its drawbacks.

That Bromide of Strontium responds precisely to this *desideratum*, has been already proved by the clinical experimentation made; the pure salt in crystalline needles, such as has been obtained by Paraf-Javal, such as is found in the solution prepared by Chapoteaut, is soluble in all proportions of water; it is with this salt and this alone, on account of its perfect preparation and absolute purity, that clinical researches have been brought to their present pitch of constancy and precision.

At the *seance* of the Society of Biology (Paris) the 17th

(2) Societe de Therapeutique (Seance du 11 Nov., 1891).

October, 1891, Dr. Ch. ere in reporting the results observed in his hospital practice t Bicetre (1), referred to the interesting case of a patient treated with 10 grammes of Bromide of Potassium daily, in whom the cutaneous eruption persisted in spite of intestinal asepsis. This patient was given the same dose of Bromide of Strontium (Paraf-Javal) and equally good effects were obtained therapeutically without any undesirable symptoms. Intravenous injections in rabbits have shown that these animals support .85 grammes of Bromide of Strontium as against .14 of Bromide of Potassium. This proves that Bromide of Strontium (Paraf-Javal) is six times better tolerated than Bromide of Potassium.

Professor Germain See says of pure Bromide of Strontium (Paraf-Javal) that "it never produces any disastrous effect on the stomach even in large doses. It may be taken in doses of 4 grammes (62 grains) at each of the three daily meals. Out of 32 patients suffering from gastric dilatation, several have been improved and some altogether cured. I believe that the Bromide of Strontium (Paraf-Javal) will advantageously take the place of Bromide of Potassium, and especially the polybromides in the treatment of Epilepsy." (Academie de Medecine, Octobre, 1891.)

The abundant evidence at our disposal proves that the pure Bromide of Strontium (Paraf-Javal) responds to the same indications as Bromide of Potassium, over which it has the immense advantage of being admirably tolerated; for even in large doses, it produces no accidents.

(1) Comptes-rendus de la Societe de Biologie (p. 665).

Dr. L. D. McIntosh, Vice-President of McIntosh Battery and Optical Company, of Chicago, died very suddenly on Tuesday, March 1st, at De Funiak Springs, Florida, where he had gone to lecture before the Florida Chautauqua, on microscopy and kindred subjects.

REFLEX IRRITATIONS AND NEUROSES CAUSED BY STICTURE OF THE URETHRA IN THE FEMALE.

BY FESSENDEN N. OTIS, M. D.

Medical Record, New York, 1892, xli., No. 2.

In this article the author advances the fact that stricture of the urethra in the female has been but little considered either in works on special diseases of the female genito-urinary organs, or in those solely devoted to the subject of urethral stricture, and hence it might be inferred to be a rare and unimportant difficulty. At the same time, symptoms occurring in the female which in the male would at once suggest the probable presence of urethral stricture, are referred to as "irritable bladder," and are attributed to causes quite independent of their possible relations to the urethra. Although over-distention in such cases is one of the most efficacious means of treatment, "examination of the urethral canal for conditions which would justify such procedure seems to have been completely lost sight of."

Organic urethral stricture in either the male or the female, in the opinion of the author, is *inevitably* due to the exudation and organization of plastic lymph in the subepithelial urethral tissues, any irritation sufficient to cause this producing stricture, though the inflammatory process may be of so low a grade as to escape the cognizance of the subject of it. Strictures are formed in this way, from the irritation of the urine, in subjects of gouty or rheumatic diatheses, practically identical with those resulting from gonorrhœa, and the foundations, at least, of the largest proportion of urethral strictures in the male are due to plastic deposits from attacks of lithiasis "often long antecedent to the gonorrhœas to which they are attributed."

After a brief reference to frequent and severe reflexes occurring in the male caused by strictures of even large calibre (brought prominently before the profession in 1874), Prof. Otis presents a series of cases to demonstrate that stricture of the urethra may occur in the female sufficient to cause reflex symp-

toms equally severe, and also that in cases where relief is not obtained from ordinary measures, the urethra should be explored by means of the urethrometer or bulbous sound, if only to eliminate an important element in the diagnosis and treatment of these cases.

In the treatment of these cases of stricture of the urethra in the female, divulsion is probably a much less serious operation than in the male, and, when carried to an extreme degree, rarely results in a permanent loss of control of the sphincter. The tendency to recontraction is marked, however, and in most instances the contractions will yield to gradual dilatation. The symptoms having once been relieved, the calibre of the canal may be maintained by the patient herself introducing the closed urethrometer into the bladder, expanding it to the degree required, and then gently withdrawing it.—*International Medical Magazine*, March, '92, p. 198.

THE RESPONSIBILITY OF SEXUAL PERVERT.

In a discussion of Sexual Perversions as related to insanity (Med. Bulletin, March, '92), Dr. E. C. Mann, after calling attention to the case of a highly educated, refined, virtuous and apparently normal minded lady patient, who suffers from epileptic vertigo, generally manifesting itself in connection with the menstrual epoch, asserts that she has had strong impulsions of disease towards crime in the form of suicide; but when these impulsions pass off, she is cheerful, sunshiny, and is a devoted wife and daughter. "Yet," suggests the writer, "it must be a very simple thing for a homicidal to take the place of the suicidal impulse, and, if she should ever in the future give way to such an impulse, the public and her friends would be greatly astonished, and perhaps, refuse to believe her responsible for it, as they have never seen any indication of mental mischief. Every physician, however, can see that the question here should be, not could she distinguish between right and wrong at the time of the commission of the act, but could she help it? Could she avoid the compulsion of disease toward crime? Was the act the outcome and product of the epilepsy? No act which is the product of disease

of the body affecting the mind by deranging its functions and causing a suspension or impairment of the healthy intellect, the emotions or the will, can be construed into a crime; and physicians should always voice this in the court room when they have to give their professional opinion. It is time that the laws should be amended to keep pace with medical science, and the absurd right-and-wrong-test of insanity, which is no test at all, should be relegated to the dark ages where it properly belongs."

This is all no doubt scientifically accurate, but we doubt not that a wide-spread knowledge of it by the medical profession, the judiciary, and the public would result in great increase in the sum total of criminality under the cloak of such protective doctrine, for, not even including in our estimate those who would take advantage of the protection without the justification of possessing any such pathological condition, the real subjects of it are no doubt deterred to a certain extent, many times, from committing crimes, though the impulsion be present, because of their accountability under existing laws.—(*Medical Fortnightly*,) March 15, 1892–p. 172.

POISONING BY COCAINE.

Berger (*Gazette des Hopitaux*, 1881, p. 1367) reported a case of poisoning by cocaine at a recent meeting of the French Society of Surgery. The patient was a healthy young man, with a hydrocele the size of a turkey's egg, very tense, which was tapped and evacuated, and a spoonful of a two-per-cent. solution of cocaine (estimated to contain forty centigrammes—about seven grains—of the alkaloid) injected and at once allowed to run out, apparently the whole quantity being recovered. An injection of tincture of iodine was then made into the sac, and the patient walked out, but soon returned complaining of feeling ill, and falling into collapse, in spite of vigorous treatment, he shortly died in coma preceded by convulsions. The autopsy revealed no other cause of death, and nothing to account for the patient's idiosyncrasy. The hydrocele-sac did not communicate with the peritoneal cavity.

In the discussion which followed, two other cases of acci-

dents after such injections for hydrocele were reported, but they were not fatal. Reclus claimed that accidents would not happen if not more than ten centigrammes (about one and one-half grains) of cocaine were employed, and he had himself operated over sixteen hundred times without any accidents. Pozzi had seen an alarming condition follow an injection of two and one-half centigrammes (less than half a grain) into the gum to open an alveolar abscess. The reviewer feels compelled to add that with such large doses as are employed in the fatal case, and other cases mentioned in the discussion, the alarming symptoms are not surprising.—(*International Med. Mag.*) March, 1892, p. 194.

LEUCORRHŒA.—Prof. C. Braun, of Vienna, recommends in leucorrhœa, associated with chlorosis, the following:

R. Ferri sulph. cryst.,
Kali carbonic. et. tartara, aa dr. j 1-4.
Extr. et pulv. r. gentianæ q. s. et fiant pil. No. 60.

Sig.—Two pills, morning, noon and evening.

If the lucorrhœa be bloody, then:

R. Ferri sulph. cryst.,
Kali hydrocarbon, aa dr. j.
Ergotin pur., gr. xxiij.
Extr. et pulv. r. liqueritiæ, aa q. s. et f. pil. No. 50.

Sig.—Two or three pills, morning, noon and evening.

If constipation be present, then:

R. Ferri sulph. cryst.,
Kali hydrocarbon, aa dr. j.
Aloes lucid., gr. xxx.

Sig.—A teaspoonful, morning, noon and evening.

Or:

R. Ferri oxidat. dialyzat., dr. j. 1-4.
Aq. f. d., f. dr. iv.
Syrup. rub. idæi, f. dr. vj.

Sig.—A teaspoonful, morning, noon and evening.

These last two formulæ are well borne by the stomach.—*Clinic of Prof. C. Braun, Vienna.*—(*Annals of Gynæcology.*)

INTERNATIONAL PERIODICAL CONGRESS OF GYNÆCOLOGY AND OBSTETRICS.

The Belgian Society of Gynæcology and Obstetrics, under the patronage of the Belgian Government, has taken the initiative in organizing "The International Periodical Congress of Gynæcology and Obstetrics," the first session of which will be held in Brussels, September 14 to 19 inclusive, 1892. Three leading questions will be offered for discussion:

1st. Pelvic Suppurations; Referee, Dr. Paul Segond, Paris.

2d. Extra Uterine Pregnancy; Referee, Dr. A. Martin, Berlin.

3d. Placenta Prævia; Referee, Dr. Berry Hart, Edinburg.

Fees: Members participating in first session, 30 francs. (This will entitle the holder to a copy of the proceedings of the congress.)

Founders (Life Membership), 300 francs.

In connection with the congress, there will be an international exposition of instruments and appliances, pertaining to gynæcology and obstetrics.

All communications pertaining to this congress should be mailed direct to the American Secretary, Dr. F. Henrotin, 353 La Salle Ave., Chicago, who will promptly furnish all information. All notifications to be forwarded should be received by August 1st.

Everything points to a great success in this congress. Though notices concerning it have been rather late in this country, already men of celebrity have promised to visit and contribute papers. Among the many foreigners who have written to the secretary general endorsing and promising support to the undertaking, may be mentioned the following eminent men:

BELGIUM—De Roubaix, Sacre, Mirriar, Pigeolot, Charles, Sanpart and others.

FRANCE—Pean, Demous, Fochier, Auvard, Doleris, Pozzi, Tarnier, Budin, Terrillon, Terrier and others.

ENGLAND—Lawson Tait, Wm. Priestly, Champneys, G. Elder, J. White, Watt Black, Thornton, Doran, Spencer Wells, Bantock and others.

GERMANY—Martin, Leopold, Sänger, Gusserow, Veit, Winckel, Hegar, Kaltenbach, Freund, Heyder and others.

SWITZERLAND—Reverdin, Vuillet.

RUSSIA—Slaviansky.

SWEDEN—Saliss, Westernark.

NORWAY—Statfeldt, Howitz, Meyer.

ITALY—Porro, La Torre, Mangiazalli, Bozzi, Morisani.

TURKEY—Chatazian.

HOLLAND—Stokvis, Treub, Nyhoff.

AUSTRIA—Pawlik, Albert, Olirobuk.

FINLAND—Engstrom, Heinricius, Pippingohold.

Further details will be furnished as soon as received.

NEW BUILDINGS FOR THE JEFFERSON MEDICAL COLLEGE OF PHILADELPHIA.

The Board of Trustees and the Faculty of the Jefferson Medical College have just completed the purchase of two large lots on Broad street, upon which they will proceed to erect at once, a handsome hospital, lecture-hall and laboratory building. The estimated cost of the building is $500,000. The hospital will be built not only as a suitable building in which to care for the sick and injured, but also will be provided with a large amphitheatre for clinical lectures. The basement of the hospital will be given over to the various dispensaries, each of which will be provided with large waiting and physicians' rooms as well as rooms for direct teaching of the students. By the erection of three commodious buildings, the laboratory where delicate work with the microscope is carried on, will be separated from the college hall where didactic lectures are given and so will be free from any jarring produced by the movement of large classes. Further than this immediately across the street is the Howard Hospital, and on the adjoining corner the Ridgeway branch of the Philadelphia Free Library, which contains all the scientific works belonging to this wealthy corporation. The new site is even more favorably situated in regard to the centre of the city, than the old one at 10th and Sansom streets.

The buildings will be ready for occupancy in the session of '93–'94.

NOTE RELATIVE TO THE BUFFALO LITHIA WATER.

BY WILLIAM A. HAMMOND, M. D.

There is a point in relation to the therapeutical efficacy, of the Buffalo Lithia Water which has not yet, I think, received sufficient attention. It is well known that many cases of diseases of the nervous system are complicated with lithæmia, and that unless this condition is removed, a cure is very often retarded and not infrequently entirely prevented. It is quite commonly the case that in cerebral congestion producing insomnia, nervous prostration resulting from over-mental work, or much emotional disturbance, and in epilepsy (to say nothing of many cases of insanity,) an excess of uric acid in the blood is often observed. This state appears to be altogether independent of the character of the food, for no matter how careful the physician may be in regard to the diet of his patient the lithæmic condition continues. I have tried to overcome this persistence by the use of phosphate of ammonia and other so-called solvents for uric acid, but without notable effect.

Several years ago, however, I began to treat such cases with Buffalo Lithia Water with a result that was as astonishing to me as it was beneficial to the patient, so that now in all cases of nervous diseases under my charge, in which there is an excess of uric acid in the blood, I use Buffalo Lithia Water in large quantities. By this, I mean that I do not have the patient drink merely a tumbler or two in the course of the day, but that I flood him, so to speak, with the water, making him drink a gallon or even more, in the twenty-four hours. By this course the urine after a few days ceases to deposit uric acid crystals on standing, the morbid irritability of the patient disappears, the tongue becomes clean, the wandering pains in the head are abolished, and the system is rendered much more amenable to the special treatment which may be necessary for the cure of the disease from which the patient suffers.

I have tried carbonate of lithia dissolved in water in various proportions, but it certainly does not, in cases to which I refer, have the same effect as Buffalo Lithia Water.

Washington, D. C., Jan. 25, 1892.

The committee appointed at the last meeting of the American Medical Association to consider the best means for promoting the prosperity of the sections of the association, will hold an adjourned meeting at the Hotel Cadillæ, Detroit, Mich., June 6, at 3 P. M.

Members of the committee are requested to notify the chairman of their intention to be present at this meeting.

The committee would esteem it a favor if each member of the association would communicate in writing his or her views concerning the best measures for promoting the development of the sections. Such communications may be sent to the chairman of the committee.

JOHN S. MARSHALL, M. D., Chairman.
9 Jackson St., Chicago.

Dr. C. S. Robinson, Richford, Tiago Co., N. Y., says: I have tried papine (Battle & Co.) and I find it possesses the medicinal virtues of opium, unalloyed with the drawbacks following the use of other forms of the drug. I tested papine in my own case, having used many forms of opium, during forty years, but only in acute attacks. It is not harmful like crude opium, morphine and other preparations, in delicate or irritable stomachs; on the contrary, it is acceptable as cordial. Also, the head is not made ill as it is by the other forms of opium that have come under my observation during most half a century. Papine is more prompt than morphine, except when the latter is used hypodermically. My wife has acute rheumatic attacks, and so-called "sick-headaches," and long ago decided she was unable to bear morphine or opium treatment. On hearing me extol papine, she tried it unbeknown to me, and afterwards reported, saying: "I believe it is indeed a good remedy; I can take it, for it does not make me sicker when I am sick."

Editorial.

RAILROAD SURGEONS AT CUT RATES FOR SERVICES.

The medical profession, in this age of progress, is not only wide awake to advancement in knowledge, but is actuated by an *esprit du corps* which frowns upon anything which detracts from the high standard of character which has hitherto marked its attitude before the public. All competition not based upon merit should be discarded from the plans adopted in the race for preferment, and no respectable practitioner should entertain a proposition to do service at less than the recognized rates of the locality in which his lot is cast. By so doing, he not only lowers himself in the estimation of all honorable members of the profession, but does great injustice to others who are competitors for the patronage of the people.

It may be that one occupying a position as Railroad Surgeon cares nothing for these things so long as the money comes into his pocket. In this case an appeal to his pecuniary interest is the best mode of approaching him. It is evident that if all who desire employment in this line shall be firmly united in refusing positions except upon a regular basis of compensation, the authorities of the railroad companies must come up to the requirements. Will there be found men amongst us with such a craven spirit as to undertake the duties of a railroad surgeon at any price which may be fixed by the officials? If so, it may soon reach a point that work of all kinds, at all times and under all circumstances, will be imposed upon them for a mere pittance and the privilege of free passes over the roads. At present the schedule of rates enforced by some railroad companies is barely sufficient to meet the expenses incurred by the professional employe, and doubtless there are instances in which those who are called away from their private patients incur absolute loss in the discharge of their obligations to the company employing them. We hear some one say that I will take care of my own interests in this matter, and don't need

any suggestions from others who cannot secure such a position. It is, doubtless, in the estimation of such an one, another case of sour grapes which actuates the criticism upon his course, and the complaint is thought to arise from inability to secure employment in this line of service. If such a feeling prompted this protest against the degradation of the profession, the writer would be amenable to the charge of envy or jealousy towards his colleagues. But the fact of his occupying an independent attitude enables him to speak out without prejudice in regard to an evil which is rapidly sapping the self-respect of every professional employee of railroad companies. Not only are poorly compensated services to the injured exacted, but the medical attendant is expected to favor the road in his testimony in an action for damages, and upon failure to do so, is liable to be dropped. An indignant representative of the interests of a railroad company retorts that no fee could induce him to give false testimony in a court of justice. But we must remember that facts have many shades of coloring for a medical witness, and the presumption is always greatly in favor of leaning to the side of the employer, and especially when the further connection of the witness with a railroad depends upon his turning a blind eye to whatever militates against its interests. All who have heard the testimony of railroad surgeons in damage suits will appreciate the awkward attitude in which he is placed under such circumstances.

An independent attitude, with regular rates of compensation for services rendered to railroad companies by the members of the medical profession, will do much towards relieving the position of its embarrassment.

There are grave questions of ethics involved in the existing relations of railroad surgeons, which do not come within the scope of this remonstrance against accepting positions without proper compensation.

It is intended to treat this purely as a business matter, and to urge upon all concerned strenuous resistance to the encroachments upon the rights and standing of otherwise worthy members of the profession.

The railroad companies cannot afford to employ an inferior man on account of his low price for services, and they should be made to understand that a good man cannot be had at a discount from regular rates.

RAILROAD SURGEONS.

Considerable interest has been manifested in the "railroad surgeon" since the subject was brought up in the American Medical Association, particularly so as they appointed a committee to report on this subject at their next meeting. Their action has caused more or less discussion in the different journals, and will probably cause the subject to be brought before at least some of the State medical associations that affiliate with it.

The tenor of some of the articles, and of a good many of the personal discussions we have heard, has been that the "contract railroad surgeon" should either be censured or expelled from the associations.

As one who has done this class of surgery for several different roads for a number of years under the different methods of compensation, I think my experience entitles me to some voice in the matter, and I think I can speak impartially of the injustice that has been or can be done these surgeons, as I have no connection with any railroad.

In the first place they strike entirely at the "railroad surgeon," when the "accident insurance companies' surgeons" are regulated by a similar tariff. So far as the "contract" part is concerned, every life insurance medical examiner, those surgeons or physicians who have contracts to do work for the various convict camps, cotton mills, machine shops and other places where medical or surgical services are needed, whether under a tariff or a fee bill regulation, *per capita* or monthly, are met by the same objections, and it is a great injustice to particularize between them, and any resolution that might be introduced should apply to all alike.

The conduct of all regular physicians is supposed to be governed by the "*code of medical ethics*" promulgated by the American Medical Association and adopted by all medical associations and societies, whether State or local, and physicians who affiliate with it. Article VII., Paragraph 1 is the only place in the "code of ethics" where there is any word said, or any rule laid down in reference to "pecuniary acknowledgements," and any one who reads it will see that there are

absolutely no grounds for the remark that I have so frequently heard, that these men should be expelled, as they are continually violating the "code of ethics" by their contracting to render medical services.

If they have violated no rule nor the code of ethics by which the associations are governed, what right have they to take action of any kind in the matter, whether it be one of censure or expulsion? Of course it may be said that the sentiment of the members are against it. That may or may not be true with the majority of members. Personally, a man has a right to his own opinion in this matter, and to freely express it. But has he any right to cast his vote for a resolution, if one should come before an association of which he is a member, that could only result in embarrassing it?

If such a resolution should be passed, it would not only drive many good members from our midst, but might have a further reaching effect.

If a member was expelled, he could by legal action, have himself reinstated as a member. In this connection, I think the older members of the association will recollect having expelled a member on a question of "sentiment" and that they were very glad to reinstate him in order to remove the question of damages done him, by their action, from the courts.

In reference to this question of damages, a member who is even censured, if he could prove damages, could recover a good round amount by legal action against the association. Well, some one will possibly say, if he did, there is no money for him to recover. But he should remember that none or very few medical associations are chartered, and your lawyer will tell you that in case they are not, each individual member is responsible for the amount of any suit brought, and that it can be collected from him.

This is only intended to open up the way to a further discussion of this very important subject, to which there are so many sides to view it from.

W. F. W.

PRELIMINARY PROGRAMME OF THE MEDICAL ASSOCIATION OF GEORGIA.

TO BE HELD IN COLUMBUS, GA., APRIL 20TH, 21ST AND 22D, 1892.

The President's Annual Address—G. W. Mulligan, M. D., Washington.

Cough—Some of its Causes and Treatment—Chas. D. Roy, A. B., M. D., Atlanta.

So-Called Typho-Malarial Fever—W. P. Williams, M. D., Waycross.

Preliminary Observation on the Behavior of Iodine in the Presence of Camphor, Menthol, Thymol, etc.—R. J. Nunn, M. D., Savannah.

Some Observations upon Cataract Operations and After Treatment—A. W. Calhoun, M. D., Atlanta.

Remittent Fever—A. C: Blain, M. D., Brunswick.

Extirpation of Rectum for Carcinoma—J. McF. Gaston, M. D., Atlanta.

Some of the Fads and Fancies of the Medical Profession—J. C. LeHardy, M. D., Savannah.

Treatment of Pneumonia, with Report of Cases—H. Perdue, M. D., Barnesville.

How shall we Manage the Uterus after Abortion?—K. P. Moore, M. D., Macon.

Plaster of Paris in Surgery—W. F. Westmoreland, M. D., Atlanta.

Report of Surgical Cases from my Note Book—J. B. Hinkle, M. D., Americus.

What is Gynæcology?—R. R. Kime, M. D., Atlanta.

A Case of Ovarian Cysts—J. M. Spence, M. D., Waresboro.

Some Remarks on Tonsil Excisions, with Presentation and Description of a New Instrument—A. G. Hobbs, M. D., Atlanta.

How Best to Conduct Labor to Prevent Injuries to the Os Uteri and Perineum—A. W. Griggs, M. D., West Point.

Gunshot Wounds of Eye—Unusual Results—Geo. A. Wilcox, M. D., Augusta.

The Treatment of Abortion and some of the Complications—Walter A. Crow, M. D., Atlanta.

Report of Case of Catalepsy and Treatment—Albert Sydney Johnson, M. D., Bowman.

Typhlitis and Report of Case—S. M. Mathews, M. D., Quitman.

The Relations and Dependencies Existing between the Specialist and General Practitioner of Medicine and Surgery—J. W. Griggs, M. D., West Point.

The Relation between Skin Diseases and the General Health—M. B. Hutchins, M. D., Atlanta.

Treatment of Hæmorrhoids by Carbolic Acid Injection—J. W. Hallum, M. D., Carrollton.

Hemeralopia or Night Blindness—S. Latimer Phillips, M. D., Savannah.

A Combination of Carbolic Acid and Camphor, as an Antiseptic—Wm. Perrin Nicolson, M. D., Atlanta.

Chorea—Hugh Hagan, M. D., Atlanta.

Antiseptic Surgery—Ralph E. Smith, M. D., Atlanta.

Radical Surgery the Best Surgery in the Treatment of Extensive Lacerated and Contused Wounds of the Extremities—E. H. Richardson, M. D., Atlanta.

Typho-Malarial Fever—J. W. Duncan, M. D., Atlanta.

The Action of Fibroid Tumors after the Menopause—Virgil O. Hardon, M. D., Atlanta.

Intestinal Obstruction, Varieties, Diagnosis and Treatment.—J. B. Hinkle, M. D., Americus.

Report of Perineal Sections for Stricture, Stone in Bladder and Cystitis—Floyd W. McRae, M. D., Atlanta.

Suprapubic Lithotomy with Report of Cases—W. S. Elkin, M. D., Atlanta.

Typhlitis—William O'Daniel, M. D., Bullard.

G. W. MULLIGAN, M. D., President.

DAN H. HOWELL, M. D., Secretary.

ERRATA.—In the March issue we wish to call attention to the following error in the article of Dr. E. H. M. Parham on Malarial Hæmaturia: "Drs. Thos. and Wm. L. Parham, both of whom were graduates of the University of Pennsylvania. I did an extensive practice," etc., which should have read, "both of whom were graduates of the University of Pennsylvania, and did an extensive practice."

Special Notes.

SANDERS & SONS' EUCALYPTOL EXTRACT (EUCALYPTOL). Whenever mention is made of "Oil of Eucalyptus" we beg you to bear in mind that such reference applies to our preparation, styled for distinction, "Eucalypti Extract (Eucalyptol.)" To avoid disappointment we would suggest to specify, when prescribing, our manufacture. Samples gratis through Dr. Sander, Dillon, Iowa. Meyer Bros. Drug Co., St. Louis, Mo., Sole Agents.

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Dose—A teaspoonful in water, gradually increased to a tablespoonful, three or four times daily.

ALTHOUGH our Verrhus Clemiana has been before the medical profession for only about two months– too short a time to be fully tested in the chronic diseases for the cure of which it is recommended—we have received quite a number of letters setting forth the flattering results already obtained. We submit the following extract as a sample :

"Tried your Verrhus Clemiana on patient with large ulcer on leg, using Ichthyol externally. Ulcer has healed, and lady quite well. Commenced treatment February 3d two teaspoonful doses.

"Am using it in a very bad case of syphilis which had resisted everything I could think of. The large copper colored blotches are disappearing, ulcer on leg much better.

"L. W. WHITNEY, M. D.,
"112 West Madison St.

"Chicago, March 7th, 1862.

BEDFORD, PA , March 22nd, 18

The Clemiana Chemical Company, Atlanta, Ga.

Gentlemen :—The bottle of Verrhus Clemiana received and used in a case of Chronic Blood Poison. It has produced remarkable results in restoring the vital forces I would like to have two bottles more.

Will remit on receipt of bill.

Very truly yours,
A. ENFIELD, M. D.

We will be exceedingly obliged to all physicians who will report their experience in the use of this medicine.

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Be sure to read Sharpe and Dohme's advertisement on 5th page. Their new preparation of Ergotole is all they claim it to be, and is highly endorsed by the profession, as their other highly and well known preparations are. Samples and circulars sent upon application.

E. Fougera & Co., N. Y., Agents for Rigaud & Chapoteaut, Paris, France. The preparations are: Vin de Chapoteaut, a typical nutritive stimulant; Apioline, a reliable emmenagogue; Ferrum Sanguinis; Morrhuol—the active principles of Cod Liver Oil and Santal-Midy—used in gonorrhœa. See ad.

MESSRS. RENZ & HENRY—Gentlemen: In response to your inquiry regarding the results which I have obtained from the use of your preparation, the "Three Chlorides," I will state that I am only too glad to express my opinion of it, and to permit you to use such opinion in such manner as may seem suitable in calling the attention of the profession to your Elixir.

I have been using your Elixir of the Three Chlorides quite extensively in my practice; I began its use at the suggestion of my esteemed friend, Prof. John A. Larrabee, of Louisville, Ky. I have found it deserves all the praise which he gave it.

Having largely an office practice, I am necessarily brought in contact with the very class of cases of chronic ailments for which your Elixir is recommended; wherever I want an alterative and tonic combination, the Three Chlorides is my favorite formula.

In chronic syphilis and the post-syphilitic cachexia, it is of especial value. In chronic skin affections I have found it a valuable adjuvant to the usual lines of local and general medication.

Patients take it readily; it acts well and is not a quack preparation, but is a reliable and open formula, and I see no reason why it should not be extensively prescribed by scientific practitioners.

I will state that I have recommended the Three Chlorides in a recently published Monogram on Varicocele.

I am, gentlemen, very faithfully yours,

G. FRANK LYDSTON, M. D.,

Professor of the Surgical Diseases of the Genito-Urinary Organs and Syphilology in the Chicago College of Physicians and Surgeons.

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NO WATER PIPES IN BED ROOMS.

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Physicians sending us patients may rest assured that they will receive the best care and attention in every particular, and reports will be made every few days. Special rates will be made for the wives and daughters of Physicians and Clergymen.

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Please mention Southern Medical Record

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R. Strychninæ sulph., gr. 1-36.
Acidi phosphorici, dil. mxx.
Glycerini, dr. ss.
Aquæ, q. s., dr. j.

S. At one dose, three times a day, before meals.—*Times and Register.*

CONVULSIONS OF TEETHING.—

R. Chloral hydrat., gr. xv.
Potass. bromide, dr. j.
Syrup simplic, f dr. v.
Aq. distillat., f oz. ij.

M. Sig. Teaspoonful every three hours.—*Kinder-Arzt.*—*St. Louis Clinique.*

SWOLLEN EYES.—If the eyes are swollen use on them:

R. Acid boracic, gr. xij.
Aquæ camphoræ,
Aquæ dest., aa oz. ii.

Bathe and drop in the eyes frequently.—*Med. Brief.*

LAXATIVE FOR CHILDREN.—

R. Manna, dr. vi.
Magnesia,
Sulphur, aa oz. iss.
Mel., dr. vi.

M. Sig. One or two dessertspoonfuls in a cup of warm milk or weak tea —FERRAND in *Gaz. de Gyn.*

TO ABORT BOILS.—

R. Camphoræ, 2 drachms.
Chloroformi, ½ ounce.

M. et solve. Sig. Apply with tip of finger hourly for one day. It will abort all boils when used before suppuration has begun.

FOR COUGH.—For severe coughs and colds, when the ordinary expectorants fail to accomplish their object, the following has often been found serviceable:

R. Ext. yerb santa fl.
Ext. grindelia robusta aa oz. ss.
Syr. prunus virg., oz. ij.

M. Sig. Teaspoonful every two or three hours.—*Med. Summary.*

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In *neuralgic cephalalgia* and in the *early stage of la grippe*, when the patient complains of pains and aches from head to foot, the following has answered admirably. It also causes a reduction of temperature in la grippe:

R. Quininæ sulph , gr. ix.
Antipyrine, gr. xviij.
Ext. hyoscyami, gr. iij.

M. Ft. capsul. No. vj. Sig. One capsule every two or three hours.—*Ex.*

For Cough.—

R. Potassii iodidi, 1 drachm.
Potassii chloras, 1 drachm.
Liq. acidi carb., 4 minims.
Syr. aurantii, 2 ounces.

M. Sig. Teaspoonful every four hours until relief is obtained.

I find the above prescription to be the best cough mixture I ever tried. It will stop a cough of long standing in three days.—Watt, in *Med. Brief.*

Incontinence of Urine.—For *incontinence of urine* in children due to exposure to cold, Professor Hare recommends the following treatment:

Where the urine is high-colored and concentrated, and the child has fever, give—

R. Tinct aconit., gtt. xij to xxiv.
Spt. ætheris nitrosi, f. dr. ij to iv
L q. potass. citratis, ad f oz. vj.
M. Sig. Drachms ii every three hours.

After the urine has become more diluted, belladonna can be given with advantage, to allay the irritation and spasm of the bladder

Or when the incontinence is due to paralysis of the bladder, give—

R. Extract nucis vomicæ, gr. ij.
Acid arseniosi, gr. 1-8.
M Fiant pil. xx.
Sig. One pill three times a day —*Coll and Clin Record.*

Pruritis Ani. Doctor Joseph M. Matthews has obtained excellent results from—

R. Benz. oxide zinc oint.
Campho-phenique, aa oz. ss.
M. Apply as often as necessary.

The campho-phenique may also be used pure, without detriment to skin or mucous membrane.—*Med. Bulletin*, February, '92.

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It is put up in plain twelve ounce bottles and is sold only on prescription of the physician, it being strictly confined to the medical profession, by whom it is highly recommended for its therapeutic qualities.

Does not deteriorate with age, as do emulsions of all kinds, but is always fresh and pure, and ready for use.

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*Abridgement of paper presented by invitation to Alabama State Medical Association during its session in Montgomery, April 13th, 1892.

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"Am using it in a very bad case of syphilis which had resisted everything I could think of. The large copper colored blotches are disappearing, ulcer on leg much better.

"L. W. WHITNEY, M. D.,
"112 West Madison St.

"Chicago, March 7th, 1882.

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I have been using your Elixir of the Three Chlorides quite extensively in my practice; I began its use at the suggestion of my esteemed friend, Prof. John A. Larrabee, of Louisville, Ky. I have found it deserves all the praise which he gave it.

Having largely an office practice, I am necessarily brought in contact with the very class of cases of chronic ailments for which your Elixir is recommended; wherever I want an alterative and tonic combination, the Three Chlorides is my favorite formula.

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Patients take it readily; it acts well and is not a quack preparation, but is a reliable and open formula, and I see no reason why it should not be extensively prescribed by scientific practitioners.

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foreign substances which have been used to check the hemorrhage, thoroughly irrigated with bichlo. of mercury solution 1-1000, all hemcrrhage checked by catgut ligature, and the wounded surfaces dressed with bichlo. gauze. The old axiom, "cleanliness is next to godliness," is no less true to-day than in the time of our fathers. It not only gives health and life to lacerated tissues, but enables them to progress to a healthy condition and in much less time to recover. If this be true in minor operations, how much more important it is in all operations on a large scale.

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drainage is as near perfect as Sanitary science can make it The house-keeping will be in ge of a most Cultured and Experienced Lady, who is widely known for her excellence and rior merit in this particular. The CUISINE SHALL BE THE VERY BEST, and the service in y respect as good as it can be made.

A MATERNITY DEPARTMENT, where everything is as near ASEPTIC as possible, and in ge of nurses educated and trained especially for this purpose, is an especial feature of nstitution.

THE SURGICAL DEPARTMENT, under same roof but disconnected from the main building, near ASEPTIC as it can be. We have a full corps of competent Physicians to assist us. sident Physician, with a cottage on the grounds, will be in constant attendance. Our es are all ladies of education and training in their profession, most of them coming it from the Woman's Hospital, New York.

Physicians sending us patients may rest assured that they will receive the best care and tion in every particular, and reports will be made every few days Special rates will be e for the wives and daughters of Physicians and Clergymen.

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DRS. HOLMES & DAVIS, Rome, Ga.

se mention Southern Medical Record

alone, he has found to act upon the system and produce an increase of the hæmoglobin.

Dr. Gottheil, lecturer on dermatology at the New York Polyclinic, uses in all acute inflammatory skin diseases the following mixture with marked success, where pain, burning and intense itching are very prominent symptoms.

℞ Tr. Opii ʒ ss—ʒ 1-8
Oil of Cade ʒ ss.
Carbolic acid gtt. xx.
Simple Syrup ℥ ss.

M. et S.

In chronic noninfections, inflammations such as parenchymatous dermatitis with ulcer, he has found europhen to give very good results as a stimulant to granulating tissue, used in the strength of from one-half a dram to a dram of the powder to an ounce of ointment. In epithelioma as a routine treatment he uses Marsden's paste which is composed of equal parts of arsenious acid and powdered gum-acacia with just enough water to make a stiff paste. A thorough application of this will, he states, cure every case of epithelioma.

Dr. E. L. Keyes has invented a devise which has proved very efficient in his hands in controlling the hemorrhage following the operation of prostatectomy. It consists of a pad made of bichloride gauze. There are four outer layers of gauze six inches square, and six inner layers four inches square. These layers of gauze are fastened together through the centre by a strong silk thread, one end of which is attached to a small white shirt button, and the other end is drawn through the urethra by the aid of a catheter and into the cavity, left by the removal of the prostate. Another silk thread should be attached to the pad by which it can be drawn out through the suprapubic opening after the hemorrhage has been controlled.

Dr. Weir read a paper at the Surgical Section of the New York Academy of Medicine, under the title of "A Unique Derangement of the Knee Joint, Demanding Surgical Interference." The patient was a woman, 45 years of age, who had been under treatment for subacute inflammation of the knee joint, with effusion. She had met with an accident

some years ago while out driving when she was thrown forward and struck her knee against the dash-board of the wagon. This accident gave rise to no permanent effects at the time, the resulting synovitis yielding promptly to treatment. Some time later, she reappeared and complained of a tight band about the knee, with a grating sensation. She was unable to lift her foot freely and easily tripped over objects. Examination of the joint showed that the patella when moved seemed to slip over some hard body. An exploratory incision was then resorted to. The synovial membrane was exposed and divided and the opening into the joint enlarged. A satisfactory exploration with the finger could now be made and by raising the patella its inferior surface could be plainly seen. From that surface at the junction of the upper and middle third, a white duplicature was observed hanging down while the bone was thus raised and which rested between the patella and the articular surface of the femur. This thickened fold of membrane was about one-quarter of an inch broad, one-eighth of an inch thick and an inch long. The entire mass was removed, a drainage tube inserted, the synovial membrane sewn up, and the wound closed. The patient regained full power of her limb as a result of this procedure.

NICHOLSON, GA., March 5, 1892.

I am much pleased with the sample of Febricide Pills you sent me. I had a case of remittent malarial fever, in which all remedies failed to relieve the pain in the head, and I had made several visits and administered antifebrin, quinine and bromide of potassium, chloral hydrates and morphine, but the pains continued to be very severe, and on the morning that I received your sample of Febricide Pills, I was sent for in haste, the family thought that the patient was taking menengitis, and on my arrival I gave two Febricide Pills, and in fifteen minutes the patient was entirely relieved of all pain. I continued the Pills until the sample was all gone, and the pain never returned, and the patient is now well and gone to business. I never expect to be without them in my practice in the future.

W. L. HOOD, M. D.

Society Notes.

CLINICAL SOCIETY OF MARYLAND.

BALTIMORE, Feb. 19, 1892.

The 262d Regular Meeting of the Society was called to order by President Robert W. Johnson.

DR. HIRAM WOODS read a paper on "The Treatment of Granular Conjunctivitis," and exhibited patients treated by the method he now uses, viz.: that of Dr. Knapp, which is the squeezing out of the spawn-like lymph follicles by means of forceps specially adapted to the purpose. Case 1. A man with pannus of three months duration. Had been treated all this time with blue stone with no improvement. Forceps were used very gently; some granulations were pressed out. Considerable pain and much bleeding from conjunctiva ensued. Following day man's eyes were wide open and photophobia completely relieved. Squeezed out some more granulations. He came back next day with conjunctiva quite clear. Has not returned since. Case 2. Girl with so-called diffused trachoma of two years duration. Was treated all last summer with blue stone. In November was suffering intensely, the entire upper lid of right eye covered with spawn-like soft follicular granulations extending over into the ocular conjunctiva. Two operations performed. At the first nearly all the granulations of palpebral conjunctiva were squeezed out; at the second all those that had escaped in the first operation were destroyed. There was swelling and pain for a couple of days, these symptoms disappeared and photophobia also. There are still a few granulations in the retrotarsal fold which will be removed. The palpebral surface is quite smooth. Case 3. Follicular trachoma of long duration. Granulations of connective tissue variety buried deep in conjunctiva. Dense, heavy pannus along upper part of cornea and whole cornea vascular. Follicles pressed out with exercise of considerable force. Conjunctiva became perfectly smooth. After a month, inflammation was set up by small

amount of jequirity with the view of clearing up the pannus. The pannus cleared up, the photophobia has entirely disappeared and the eye is almost well. Case 4. Man troubled with trachoma for four years. Came to hospital early in January and was operated on without previous treatment. Granulations were of connective tissue kind. A great deal of thick, heavy pannus. Photophobia considerable, lachrymation much and whole eye congested. Granulations squeezed out by using considerable force. There was a good deal of pain and considerable reaction, and after two weeks the eye was watery and somewhat painful. There is now no watering, the eye is clearing up, the lid is smooth and he is in a fair way to get well of his pannus. Two other cases, both in young Jewish women, were in the atrophic stage and very little could be done except to relieve irritative symptoms. Both suffering intensely from photophobia and lachrymation. One operated on a week ago and is almost entirely relieved of photophobia. The other operated on yesterday feels better to-day than before the operation. Two cases operated upon at the hospital never returned.

His experience with these cases, together with the experience of Dr. Knapp in his 114 published cases, leads Dr. Woods to the conclusion that this is the best method ever devised for the relief of granular conjunctivitis.

DR. J. E. MICHAEL: I was for a number of years Dr. Chisolm's first assistant at the Presbyterian Eye and Ear Hospital, and I remember very vividly the many cases of trachoma that came to us day after day, month after month, and year after year to have nitrate of silver or blue stone applied, and it was our habit to regard these cases as almost hopeless I have noticed of course, a gradual improvement in some of them, which would go to a certain point and then stop. I have never seen any cases which have shown anything like the improvement seen in these cases exhibited by Dr. Woods. I want to express my satisfaction that so important an advance has been made in treating such an obstinate and troublesome pathological condition.

DR. WILMER BRINTON read a paper on "Phlegmasia Alba Dolens, with Report of Three Cases."

In about 110 cases of obstetrics, Dr. Brinton has seen three cases of phlegmasia alba dolens, or the so-called "milk-leg." The various views as to its causation were given. It is now generally held that it is caused by phlebitis, that phlebitis being an extension of the disease from the vessels of the uterus. Virchow claims it to be due to a physiological thrombosis. Case 1. Mrs. D., confined in Nov., 1884. Second child. Labor rapid. Lying-in period uneventful until 11th day. Temperature and pulse normal for seven days, the record no longer kept. On 11th day patient was found in bed crying with pain in left leg. Pulse 120, temperature 101 1-2. Had had a chill in the morning followed by feeling of malaise, and intense pain in left leg. Leg was swollen and hot to touch. Swelling much greater next day. Pulse and temperature became normal in a few days, swelling gradually disappeared first from foot, then from the calf and then from the fleshy part of the leg. It was three months before she ceased to complain of stiffness and soreness. Case 2. Mrs. S, confined by a mid-wife Oct. 8th, 1888. No trouble or complications. Remained in bed till 10th day and then resumed her domestic duties. On the night of 14th day after confinement had a chill, followed by pain through body, and intense headache. Next morning was somewhat better but could not move left leg without pain and it was rapidly swelling. Dr. Brinton was called in next day and found patient in bed, pulse 120, temp. 101 1-2. Complained of a general feeling of malaise, severe headache and very severe pains in left leg. Leg much swollen and œdematous, especially in calf and about the ankle; especially tender to touch on inner side of popliteal space. In two days swelling about ankle began to disappear. In 17 days got out of bed and soon began to move about and attend to household duties. Case 3. Mrs. T., delivered Sept. 1, 1891, of twins. It was a case of placenta prævia centralis, with much loss of blood, from which the patient rapidly recovered. Lying-in period uneventful, although pulse and temperature slightly above normal; pulse 85-100 and temp. 99 1-2–101. On 10th day sat up for a short time. On evening of 11th day temperature rose to 101 and pulse to 126. Had had decided rigor about midday. Next morn-

ing pulse 100, temp. 101. Examination revealed a case of septic endometritis due doubtless to lacerated cervix. The "skilled" nurse had given the injections in such an imperfect manner, that no benefit had been derived. On the 4th day from the beginning of the attack the left leg showed marked signs of phlebitis. Pain first felt below Poupart's ligament, and extending down the thigh to the leg. The leg became greatly swollen. In ten days painful symptoms subsided, and patient moved the limb without much pain, when suddenly pulse became rapid, temp. 104 and right leg became involved more extensively than the left. About seven weeks from time of delivery, she was able to be removed to Washington. She is now enjoying the best of health.

The treatment of these cases was by internal administration of quinine, opium, aconite and phenacetin, and locally, absolute rest of limb, application of flax-seed poultices to certain parts of limb for a few days, and later the limb was rubbed from time to time with camphorated oil and a flannel bandage applied daily from toes upward. In case three, the uterus was washed out daily for some time with bichloride solution.

Dr. W. S. GARDNER: I would like to ask Dr. Brinton if he kept the temperature record of that first case up to the time she was attacked.

DR. BRINTON: I did not. It is now several years since, but I am satisfied that the pulse and temperature were practically normal; if not, I would have made a record of the case.

DR. GARDNER: There is quite a difference between a "practically" normal temperature and an actually normal temperature. I believe that if the temperature records of all these cases are kept accurately you will find but few, if any, will have a normal temperature from the time of confinement till the time that phlegmasia alba dolens comes on. I think it is a fact that is about as well established as anything connected with septic troubles of the puerperal state, that this is one of the conditions that we have as a result of septic infection; that it is nothing more than a connective tissue inflammation in the leg, due to sepsis. The clot in the veins is entirely a

secondary affair, and has nothing materially to do with the condition. There are many post-mortems reported, in which there were no clot and no phlebitis. Even if this were not the case, the retarding of the return flow of blood would not give the condition found in phlegmasia alba dolens. Retarding would give you a simple œdema; in phlegmasia you have in addition to œdema, what seems to be more of an inflammatory condition, although it is not associated with the redness of ordinary inflammation; it is an infiltration into the tissues instead of a pouring out of serous fluid into spaces beneath the skin, so that the limb becomes practically solid and does not pit readily on pressure.

So far as the treatment of these cases is concerned, it is just the treatment of all our infectious diseases except syphilis and malarial fever. You cannot do anything with them; they either get well or they die. You cannot cure typhoid fever, nor scarlet fever nor phlegmasia alba dolens, nor troubles where there are micro-organisms developing in the tissues. You can only treat the symptoms as they arise.

DR. J. E. MICHAEL: The question as to the necessarily septic nature of phlegmasia alba dolens is not by any means settled, and Dr. Gardner's statement that a careful record would in all cases show a rise of temperature or other conditions indicating a septic state of the patient, is not carried out by the facts in many instances. I am convinced that Dr. Brinton's cases are as he stated them to be. He took the temperature for a certain number of days and finding no rise did not take it again. I have seen one case of phlegmasia. The woman was dropsical, badly nourished and badly cared for. She had general œdema and œdema of the lung, and every evidence of advanced kidney disease. She was confined sucessfully. For several days her temperature was normal, that is under 100 degs., for we regard, in such cases, anything under a hundred as normal. On the 12th day there was the sudden occurrence of pain and the other symptoms which Dr. Brinton has given as indicative of beginning phlegmasia alba dolens, and the case turned out to be so, and had a fatal issue. The uterus, vagina and everything connected with the generative organs were absolutely free from any evidence of previ-

ously existing inflammation. There was a clot in the femoral iliac vein which had undergone softening, and was described by the pathologist as the "puriform softening of Virchow." I think there is a question if there was anything which comes under the description of puerperal septicæmia and its various manifestations. What adds to the interest of this discussion is the statement made by Dr. Brinton, which is in accordance with our histories and experience, that cases of phlegmasia alba dolens occur, as a rule, in patients having a normal puerperium. The condition of the blood, or whatever it may be which predisposes it to easy clotting, is undoubtedly, according to the views of Virchow, responsible for its clotting under these circumstances. I am convinced that at least a portion of these cases are not associated with distinct phlebitis, but are the result of primary clot formation and do not begin till the clot is formed.

The other side of the case, and one that is taken by a good many, including Dr. Gardner, is that phlegmasia alba dolens always indicates a septic condition. I am inclined to think that there is a septic condition which produces, clinically speaking, the same condition which we find in phlegmasia alba dolens. We have the occurence of phlebitis in the neighborhood of the generative tract and in the adnexa and we may have a phlebitis which would involve the femoral vein and would produce the clot and the general train of symptoms following. I do not think we have grounds for sepsis in all the cases. I believe the only satisfactory solution can be arrived at by gathering together all possible information about the occurrence of this disease in lying-in hospitals now and comparing it with its occurrence in years gone by, when septic conditions prevailed to such an extent. Virchow says that in the examination of these clots in cases that terminate fatally we have an appearance of pus surrounding the vessel and which would on careless examination be taken for pus, but in which the most scrutinizing examination reveals no pus and no bacteria; so I am inclined to think that we can have phlegmasia alba dolens with no septic infection whatever. I am inclined to think that two of the cases spoken of by Dr. Brinton were of this kind.

Another point bearing on this subject in a most practical way is that in by far the great majority of cases where we do have positive puerperal septicæmia we do not have phlegmasia alba dolens.

DR. J. H. BRANHAM: As Dr. Micheal has said, it is difficult to decide whether all cases of this disease have the same cause. Where there is a clot in the vein, if the trouble begins as an infection the organisms enter some of the uterine vessels and gradually extend to the larger vessels; this is the theory maintained by many good observers. If it is simply clotting of blood extending from the smaller veins into the larger ones, this can occur without sepsis. Some cases are not accompanied by these clots at all; in these cases the swelling is due, I think, to stoppage of the lymph vessels.

The occurrence of chill, and the rise of temperature and pulse in these cases look as though there was some form of septic infection. I do not believe that simply stoppage of circulation without some infection in addition causes these symptoms. As to how the infection gets there, there is some doubt. It is well known that we may have a very late form of sepsis in obstetrical cases. Without any previous rise of temperature decided septic trouble may come on, ten to eleven days after labor. Either there was a late infection or there was at first a very slight infection, and then it took time for sufficient development of the organisms to produce decided septic symptoms.

DR. W. S. GARDNER: With reference to the history of these cases, we know that it is an extremely rare disease. Tyler Smith gives us a history of one man having three successive cases of labor, in each of which phlegmasia alba dolens occured. There was another series of three successive cases in this town a few years ago. While these series of cases are very short and might be considered as incidences in any ordinary disease, yet considering the extreme rarity of phlegmasia alba dolens, I think a series of even three cases is strong presumptive evidence that it must be due to something which can be communicated by some one to the patients.

If the remarkable degree of disorganization which is

found in these cases is not due to micro-organisms, how then are you going to account for it?

DR. BRINTON: I am inclined to think that sepsis is the cause in a certain number but not in all cases.

As to normal temperature: In the vast majority of cases, I think that the temperature will be 98—99 deg., and that in many cases there is a normal temperature of 100.5. In some cases where the temperature has been 100 deg., the lying-in period has been as uneventful as where the temperature was 98.5 deg.

W. T. WATSON, M. D.,
Secretary.

1603 N. Broadway, Baltimore, Md.

GEORGIA STATE MEDICAL ASSOCIATION.

FORTY-THIRD ANNUAL MEETING, HELD AT COLUMBUS, APRIL 20, 21 AND 22, 1892.

FIRST DAY—MORNING SESSION.

The Association convened in Springer's Opera House, and was called to order at 11:25 A. M. by the President, Dr. G. W. Mulligan, of Washington.

THE ADDRESS OF WELCOME was delivered by the Hon. J. J. Slade, Mayor of Columbus, which was responded to by Dr. J. B. Baird, of Atlanta.

Prayer was then offered by the Rev. Robert Harris.

President Mulligan delivered his annual address, in which he pleaded for the abandonment of all unscientific methods of reasoning and investigation, and for a still firmer alliance with those principles which, in other branches of knowledge, have produced such brilliant successes. He pleaded for a less reliance on the blind gropings of empiricism and a still closer affiliation with every method of modern science. He also pleaded for the exclusion of all fallacies and the adoption of every safeguard which may indicate a wrong direction in our studies, and for the entire displacement of self in the investigation of life, both in health and disease, and a concentration of all our powers in searching out and fortifying the laws governing the relation and succession of these phenomena.

DR. J. M. SPENCE, of Waresboro, read a short paper entitled "A Case of Ovarian Cyst."

May 1, 1890, he was called in consultation with Dr. W. P. Williams, of Waycross, to see a case. Five years prior to his visit the patient gave birth to twins, attended, however, with great difficulty. An undergraduate attended her. Her health was apparently good until she became pregnant again twelve months hence. The issue of the second pregnancy was triplets, the patient again enduring a state of prolonged labor and excruciating pain under the supervision of the same quack. In about two months something began to grow in the region of the right ovary. It grew rapidly for about three years. After a careful examination, an exploring needle was introduced, which, on its withdrawal, was found to contain a thick, dark straw-colored fluid, about the consistency of ordinary syrup. The legs and whole lower extremities were infiltrated with water, her tongue coated, and bowels costive, the infiltration being caused by compression of the tumor on the kidneys and ureter. They next took a measurement of the abdomen, which was six and one-half feet, and from the pubes to the ensiform appendix the distance was three feet and nine inches. Calomel, pulverized rhei, carbonate of soda in repeated doses, together with iron, strychnine and digitalis, were given for a few days. Six days later they met and introduced a trocar and canula through the walls of the abdomen, and through the aperture thus made there came seventy quarts (which seems almost incredible) of a thick straw-colored fluid. The same treatment was continued at their second visit, two weeks later, and at this time twenty-eight quarts of a similar fluid were withdrawn, together with something that looked like human brains. At a third visit, two weeks later, they drew thirty quarts of similar fluid, but the trocar would frequently become choked with the brain-looking matter discovered after the operation. Ten days later the patient was seized with cholera morbus and died.

DR. D. C. HURT, of Columbus, followed with a paper on "The Influence of Civilization and Social Life upon Women as Viewed from a Medical Standpoint." (Will appear next month.)

DR. H. PERDUE, of Barnesville, read a paper on "The Treatment of Pneumonia with Report of Cases."

Since the first of January, he had had, besides several of the lobular variety, fifteen cases of the lobar. Three of the lobar class had one lobe of the lungs affected, four had two, seven had three, and one had four. This shows an unusual *pro rata* number of lobes attacked, yet he had not lost a single case.

In lobar pneumonia he uses peroxide of hydrogen with good effect. It is given for the germicidal properties, the oxygen it furnished the patients exhilerated and strengthened them. If it nauseates—and sometimes it does—the quantity should be diminished. He feels confident it has saved valuable lives. Throughout the stages of congestion and consolidation he gives phenacetine in five grain doses in connection with whiskey or milk punch every four hours, unless the temperature should get below 103° F. Good nursing is an important factor in the management of pneumonia patients. A nutritious liquid diet, such as sweet milk, beef tea and palatable broths, should be given. In convalescence stimulating expectorants and tonics are indicated.

In catarrhal pneumonia, the supporting treatment should be given from the beginning. He generally gives carbonate or muriate of ammonia during the entire treatment. Quinine he considers a valuable remedy in reducing temperature, and as an aid to resolution. Mild mustard poultices or blisters to the chest are valuable; also flannel cloths or jackets saturated with turpentine, diluted with oil, if the patient is a child. Great care should be exercised in convalescence to prevent a relapse or a second attack.

DR. R. R. KIME, of Atlanta, read a paper entit ed "What is Gynæcology?" He briefly reviewed the progress made in gynæcology, and said the Father of Medicine recognized the sympathy existing between the mammary gland and the uterus, which he utilized by cupping them for uterine hæmorrhage.

Another twelve centuries brought us to the nineteenth century in which fads, fashions and cycles held sway as in the olden times. To illustrate: We have only to mention that a few years since everybody slit or divided the cervix; a few

years later everybody sewed it up, and now everybody divulses or dilates, and drains.

A few years since everybody probed or sounded the uterus, applied caustics to ulcers of the os. Now the sound is not often used and ulcers of the os are a nonentity. Within the last three or four decades the advancement in gynæcology has been so rapid that it is difficult to keep in the line of march as the procession advances to new thoughts and new discoveries. Ovariotomy is about the only operation that has not been greatly abused or oft-resorted to without just provocation. It first had met with violent opposition, but to-day stands as an established procedure. The improved technique with lessened mortality are about the only improvements since the operation was first performed. The speaker was glad to see gynæcology as fast approaching a scientific basis. In the last two decades, it has outstripped all other specialties of medicine in new discoveries and improved operative technique, thereby saving many of "God's noblest gift, the woman perfected."

He concluded by saying that the South had not been asleep, that she furnishes and has furnished her quota of active original workers in this specialty, that the Southern Surgical and Gynæcological Association is maintained within her borders, and among her sons may be found such names as McDowell, Sims, Talliferro, and Battey, with many other eminent active workers in that line.

Adjourned.

APRIL 21.—MORNING SESSION—SECOND DAY.

DR. A. G. BLAIN, of Macon, read a paper on "Remittent Fever."

In persons exposed to the malarial miasm, it is a good plan to give daily doses of quinine (5 to 10 grains) each morning, and they should avoid night exposure. Should the practitioner see the patient in the prodromic stage of lassitude—furred tongue, foul breath—he believes that he can often prevent an attack of remittent fever by giving a mercurial cathartic, followed by quinine and a mineral acid.

ACTUAL TREATMENT. The patient should be put to bed in a well ventilated room. Patients require good nursing. Regu-

late diet—a fluid diet is necessary and milk is the best to rely upon. The practitioner may have to boil the milk and give it iced, or he may peptonize it when necessary. He believes it best to give all nourishment in small quantities and at frequent intervals. In excessive temperature he relies upon phenacetine as the best drug at his command, in doses of from 5 to 10 grains, as the case may demand. The pain in the limbs during convalescence can be controlled by phenacetine and salol. Convalescence will be greatly assisted by a tonic of nux vomica combined with nitro-muriatic acid and some one of the bitters.

DR. W. E. B. DAVIS, of Rome, read a paper entitled "The Surgical Treatment of Puerperal Peritonitis."

He said that puerperal fever was no longer regarded as a distinct affection, a disease *sui generis*, but is looked upon as a septic fever resulting from infection during the puerperal state. When quarts and gallons of pus are reported as having been removed from the general peritoneal cavity and recovery followed, he believes that the pus has usually resulted from a local collection, which has ruptured into the general cavity and the operation has been done before sufficient time has elapsed for this amount of pus to result from the septic inflammatory process in the general cavity. It is easy to understand how a gallon of pus, which has been shut off from the general cavity by inflammatory exudations and adhesions, and which has only recently ruptured into the peritoneal cavity, can be removed and recovery follow, and it is not difficult, Dr. Davis thinks, to comprehend how this condition might be mistaken for acute general suppurative peritonitis with a gallon or quart of pus as a result in the cavity, as the pus, by its irritating properties, will produce an inflammation which would be misleading; but the condition is quite different from what would be had, if the pus had been the result of a general inflammation. Dr. Davis maintains that localized puerperal peritonitis with pus formation is a form of the disease that is amenable to surgical treatment. He had operated on cases where there seemed to be no hope of recovery, with favorable results. He had seen cases, where the pulse was 135, get well after an operation for the relief of this condition.

Frequently the fever from puerperal infection may continue for weeks where there is no pus formation, and in which the ovaries are greatly enlarged, and the broad ligament thickened with occlusion of the tubes. He had operated on such a case where the tissues were so soft that his ligatures would cut through, and it was necessary to take up the vessels and ligate them separately. The ovary in this condition is as septic as if it contained pus. Frequently the masses felt in the pelvis following delivery or abortion are due to pelvic peritonitis with adhesions to the intestine and omentum, and when an operation is made to evacuate pus, we will often find in the place of pus this condition present, but where fever is kept up and the patient's condition shows sepsis, it is wiser to open the abdomen, break up the adhesions, and remove the diseased appendages, which are keeping up the infection.

Dr. K. P. MOORE, of Macon, read a paper entitled "How shall we Manage the Uterus after Abortion?" He emphasized the necessity of clearing out the cavity of the uterus in cases of abortion, and by so doing it would be the means of preventing some of the troubles with which the gynecologist has at present to deal.

DR. C. D. ROY, of Atlanta, followed with a paper on "Cough; Some of its Causes, and Treatment."

After enumerating and dwelling upon the causes of cough, he touched upon the treatment. Every source of possible irritation should be found and removed. Hypertrophies were best removed with the galvano-cautery, and polypi should be thoroughly extirpated with the wire ecraseur. All septum deviations and spurs, when prominent enough to be a source of irritation, should be removed by whatever method the operator chooses.

The speaker called attention to a cough which is sometimes present about the age of puberty, seemingly dependent upon the condition of the reproductive organs or that of the blood.

In the *Lancet* of December, 1890, Sir Andrew Clark cited several cases of this condition occurring in his practice, both in boys and girls. Dr. Leaming, of New York, who has since called attention to this subject, has reported such a condition occurring in a young girl suffering with chlorosis, following

an attack of mountain fever. The late Sir Morrell Mackenzie has also reported such a case. That there is a close relationship between certain conditions of the reproductive organs and certain nervous phenomena in other portions of the body, no one will deny, for day by day the correlation of our bodily functions is growing in importance. Dr. John Mackenzie, of Baltimore, has called attention to certain nasal conditions coexisting with a peculiar state of the reproductive organs, which from their constancy do not seem to be entirely fortuitous. In all such cases the treatment must be general, the aim of the physician being to restore the body to as normal condition as possible by rectifying all morbid states in individual organs.

Adjourned.

SECOND DAY—AFTERNOON SESSION.

DR. A. W. CALHOUN, of Atlanta, read a paper entitled "Some Observations upon Cataract Operations and After Treatment."

He reported 904 operations for cataract. The records of his first 47 cases had been lost, so that the report simply embraced the records of 847 cases. Of this number 203 were cases of soft cataract in children, and 654 cases of hard senile cataract in adults. The ages of the children ranged from three months to 25 years; the ages of the adults ranged as follows: 138 from 25 to 40 years of age; 82 from 40 to 50 years of age; 98 from 50 to 60 years of age; 157 from 60 to 70 years of age; 104 from 70 to 80 years of age; 28 from 80 to 90 years of age; 11 from 90 to 94 years of age, making 654 of hard cataracts, which, including 203 soft cataracts, makes 904. In the beginning of his cataract operations, Dr. Calhoun said if he got 95 per cent. of successes he thought he was doing well; but since the injection of cocaine and the advent of antiseptic surgery a hundred per cent. of successes has been the result in his cases.

Dr. A. A. SMITH, of Hawkinsville, read a paper on "Gunshot Wound of the Stomach with Report of a Case." The patient, a negro, had received a pistol shot said to be in the stomach. After careful examination the doctor found that in the fight, which had occurred two hours previously, his patient had received a wound directly over the stomach. A cas-

ual examination with the eye alone was all that was necessary to show that the ball had penetrated the cavity of that organ. A more thorough examination was made with the probe, and it was found that the ball had entered at a point about two inches below and to the left, at the tip of the ensiform cartilage of the sternum. The probe passed readily into the cavity of the stomach, and the doctor supposed that the ball had passed through and lodged in some other portion of the body, and did not pursue the examination further. At a third visit, which was about forty-eight hours after the boy had received the shot, he ascertained that there had been two or more free evacuations from the bowels, and to his great surprise, the ball had passed with one of these evacuations. The wound healed by first intention, and just one week from the date of the injury the boy returned to his work.

Dr. R. O. COTTER, of Macon, read a paper the title of which was "Some Practical Points in Reference to Eye Strain."

He was impressed with the observation, that the vast majority of general practitioners overlook the easily substantiated fact, that such a great multitude of morbid reflex neuroses, are brought about by eye strain; that is to say, uncorrected errors of refraction. He referred especially to hyperopia and hyperopic astigmatism. Myopes generally complain of not being able to see well enough at a distance. Headache was by far the most common accompaniment of hyperopia and astigmatism. These headaches were most common in the temples, frontal region and vertex. They frequently appeared to be what are known as sick or bilious headaches, and are in any case truly distressing in character. Correcting refractive errors was the most prominent and by far, the most scientific part of an oculist's work, and he feared that many practitioners overlooked these cases; that they met with one hundred of such sufferers, where they saw one case of cataract.

DR. R. J. NUNN, of Savannah, read a paper entitled "Preliminary Observations on the Behavior of Iodine in the Presence of Camphor, Menthol, Thymol," etc.

Alcohol.—If we take a saturated alcholic solution of iodine,

add to it as much camphor as it will dissolve, and its solvent capacity for iodine is immensely increased. In fact, it will be found that of a saturated solution of camphor in alcohol 125 minims will dissolve 50 grains of iodine.

Carbolic acid.—Liquify a quantity of carbolic acid with a little alcohol (about one per cent.), saturate the liquified carbolic acid with iodine, next saturate this iodo-phenic solution with camphor, of which it will dissolve 300 to 400 per cent. This camphorated iodo-phenol will now dissolve or appropriate iodine until it becomes a dense syrupy liquid; or

Experiment 3.—Prepare a saturated solution of camphor in carbolic acid (this formula, which is original with Dr. Nunn, and has been used by him for many years, is possessed of valuable medicinal properties, and is known locally as phenocamphique), the result of the saturation of this solution with iodine will be similar to that obtained in experiment No. 2.

Salol.—If camphor and salol are mixed in proper proportions a liquid results, which also has the power of dissolving iodine in large quantity, a blackish liquid resulting.

Thymol.—Thymol liquifies when mixed with camphor, and the resulting fluid is also a powerful solvent of iodine.

Menthol.—A mixture of menthol and camphor also liquifies, and in this liquid iodine is very soluble.

DR. WILLIS F. WESTMORELAND, of Atlanta, read a paper on "Plaster of Paris in Surgery."

The object of the paper was not to discuss the various appliances adopted by different surgeons, but to present what he regarded as the best plan; one that showed results in every particular more satisfactory to the surgeon and patient than any other plan that has been presented in the past or present. It was not every plaster of Paris splint (so-called) that is applied to a fractured bone that does well. It must be properly applied, of appropriate material, with the fragments of the fractured bone properly adjusted to give the results which are so much to be desired. For a time this splint was used only in simple fractures, but now surgeons use them in compound comminuted fractures with the very best results, often saving a life or a limb that was formerly sacrificed to the knife, or other plans of treatment that

resulted in the death of the patient. Dr. Westmoreland then gave the details of its application.

Adjourned.

APRIL 22—THIRD DAY—MORNING SESSION.

The first paper read was by Dr. L. G. Hardman, of Harmony Grove, entitled "Eclampsia after Delivery with Report of Cases," in which he summarized as follows:

1. That eclampsia does frequently occur after delivery.

2. That judging from the cases presented it occurs for the most part in patients with pyelitis.

3. That when we find pus in the urine of pregnant women and can exclude specific disease of the kidneys, any bladder or urethral disease likely to cause it, and thus feel pretty certain that the pus comes from the kidney; and if it continues and begins to cause any general disturbance of the health, he believes it is our duty to induce abortion or premature labor, and thus save our patient a great risk.

DR. A. G. HOBBS, of Atlanta, followed with a short paper on "Some Remarks on Tonsil Excisions, with Presentation and Description of a New Instrument."

The instruments exhibited were the practical outcome of the speaker's efforts through several years to do away with some of the objections to the instruments most commonly used for excising hypertrophied tonsils, as the ring tonsillotomes, the guillotines, wire loops, etc. He still, however, uses the ring blades in young children and in other cases where the tonsil projects decidedly with a base but little, if at all, larger than the body.

The objection to the guillotine or ginged instruments, was that the latter, especially, so often leave a margin of bruised tissue, which in many cases ends in slough; and, with neither of them is the operator quite certain of the exact amount of the tonsil he will clip, especially if the attempt is made on a mass that is soft, broad and nodulated. The cold wire snare causes great pain and requires a much longer time, and, moreover, it leaves a contused stump unless the whole organ be extirpated, which he never does intentionally. The hot wire, even with the most approved guards, endangers the pil-

lars and is, like the cold wire, quite a formidable instrument, at least, in the mind of the patient.

The blades of the instrument exhibited were curved both on the flat and on the edge and are in pairs, right and left. Either blade may, however, be used on either tonsil, especially if the operator is ambidextrous, by making the section upward or downward according to the curve. But in most cases it is easiest and safest to make the section upward to avoid cutting the base of the tongue; the flat curve of the blade will prevent the danger to the posterior pillar. The firm hold by the double hook enables the operator to lift the mass of tonsil tissue out of its bed from between the pillars to any extent, even when it is partly overlapped by large pillars. In a total of something over four thousand tonsil excisions, Dr. Hobbs finds himself choosing these instruments now in at least 75 per cent. of his operations.

DR. J. MCFADDEN GASTON, of Atlanta, read a paper entitled "Extirpation of the Rectum for Carcinoma."

The patient, a white man, aged sixty-two years, was referred to Dr. Gaston by Dr. J. I. Darby, of Columbia, Alabama. There was no family history of malignant disease, but his appearance led to the conclusion that there might be a cancerous cachexy. Having had occasion to report two cases of papilloma of the rectum with carcinomatous degeneration, which terminated fatally without operation, he recently advised in a similar case extirpation of the entire mass. This was done without serious consequences on May 30, 1891, and promised a good result, but there was a redevelopment of the induration above with a fatal result.

The patient referred to was received at the Providence Infirmary with rectal trouble. Upon digital examination and exploration with the speculum, there was found to exist an induration and thickening of the submucous tissues extending from an inch within the anus up to the recto-colic junction. The mucous membrane presented a dark conjested appearance attended with some oozing of blood. There was a marked contriction of the upper portion of the indurated structure, but admitting of the passage of the point of the index finger by forcible upward pressure, giving the impres-

sion that the structure above was not involved in the disease. It was therefore determined after consultation with several colleagues, that they had a case of carcinoma of the rectum of a circumscribed nature, which warranted an operation, and extirpation was performed July 8, 1891. The patient did well up to the 16th of July, when a marked change came about rather unexpectedly during the day, ending in collapse. At 11 P. M. he died of septicæmia.

DR. J. W. HALLUM, of Carrollton, contributed a paper on "The Treatment of Hemorrhoids by Carbolic Acid Injections."

In most of the cases that apply for relief it is unnecessary to delay, but the speaker proceeds at once to make a radical cure of the pile tumor. He does this by mixing together pure carbolic acid one part and pure glycerine two parts, and enough morphine and tannic acid that ten drops of mixture will contain one quarter of a grain of each. Let this be well shaken and thoroughly dissolved before using it.

The position that he has found to be probably the best is the one in which a toad assumes when in a sitting posture. In this position the patient will almost invariably pass out the tumors by an effort at straining down. There is more or less burning for a few minutes consequent from the injection, after which in the course of five or six hours the tumor begins to throb and ache from the swelling and also the death of the pile itself.

Adjourned.

THIRD DAY—AFTERNOON SESSION.

The Association re-assembled at 2:30 P. M., and after transacting some miscellaneous business, proceeded to the installation of officers. The following were elected:

President, Dr. A. A. Smith, Hawkinsville; First Vice-President, Dr. Geo. J. Grimes, Columbus; Second Vice-President, Dr. R. H. Taylor, Griffin; Treasurer, Dr. E. C. Goodrich, Augusta; Secretary, Dr. D. H. Howell, Atlanta.

On motion the association adjourned to meet in Americus, third Wednesday in April, 1893.

Book Reviews.

THE PRINCIPLES AND PRACTICE OF MEDICINE.—By William Osler, M. D., Fellow of the Royal College of Physicians, London; Professor of Medicine in the Johns Hopkins University and Physician-in-Chief to the Johns Hopkins Hospital; Formerly Professor of the Institutes of Medicine, McGill University, Montreal, and Professor of Clinical Medicine in the University of Pennsylvania. Published by D. Appleton & Co., New York, 1892.

With the light that has been thrown upon the science of medicine by histological researches and bacteriological investigations, by the additional knowledge upon old remedies and the introduction of newer ones, by the rapid strides that have been made in preventive medicine, and the knowledge gained of climatic influences upon certain diseases, the older text-books are far in the wake of this advanced period and have somewhat lost their fitness for the student and practitioner of to-day.

This work embraces all the best and most progressive views relative to the practice of medicine, and shows exhaustive research and diligent study by the author, whose wide experience and thorough fitness has placed him in an attitude to give to the profession a work which altogether meets the demand.

To the busy practitioner we commend it as being concise but thorough, to the scientific investigator it will act as a stimulant and a guide to assist in unraveling the tangled meshes and obscure points, and to the student it will serve to steer the untrained mind in the most approved channels.

C. E. J.

MEDICAL AND SURGICAL GYNECOLOGY.—By S. Pozzi, M. D., of Paris. Translated from the French by Brooks H. Wells, M. D., of New York. Volume 2 contains 305 wood engravings and six full-page plates in colors.

This work is more cosmopolitan than those of most French

writers, to quote from preface: "I have largely consulted foreign publications; and have quoted as many English, American and German as French names. It is possible I may be criticised for so doing, but 'For whoever thinks there is neither French nor English,' said Voltaire."

This work bears evidence of thought and extensive clinical experience.

He believes in antisepsis, devoting 30 pages to the consideration of the subject in detail. .

The author deals with many minor points which adds to the value of the work, while he avoids being prolix on points of little value.

The first volume also treats of anæsthesia, means of wound-closure and the control of hemorrhage, gynecological examinations, metritis, carcinoma of the uterus, displacements of the uterus, deformities of the cervix, artresia, stenosis, atrophy, hypertrophy and disorders of menstruation.

The author and translator have furnished a valuable work, and it deserves extensive sale. R. R. K.

SURGERY. ITS THEORY AND PRACTICE.—By William Johnson Walsham, F. R. C. S., Assistant Surgeon to St. Bartholomew's Hospital, etc. Third edition, revised and enlarged, with three hundred and eighteen illustrations. Philadelphia: P. Blakiston, Son & Co., 1891, pp. 15-748.

This excellent work is intended more for the student than the surgeon, but can be studied by both with benefit; it is a concise and efficient guide, and in addition is thoroughly practical.

It is abreast of the times in surgical pathology, and is ahead of most similar works in the theory of inflammation and the possibility of preventing it by the proper application of antiseptic precautions.

In the repair of fractures he describes the process of union as similar to that which occurs in the healing of a wound of the soft part by first intention, which is good sound teaching. The illustrations are well selected, and some of the original

ones are very instructive, particularly the diagrams illustrating the collateral circulation.

All through the work special prominence has been given to those subjects with which every student and general practitioner who does any surgery, should be acquainted.

The book is well gotten up and the index is particularly good. W. F. W.

A CASE OF CÆCAL HERNIA COMPLICATED BY INFLAMMATION OF THE VERMIFORM APPENDIX.

A case of this character is reported by Gangolphe (*Lyon Medical*, 24 Annee, tome lxix.) The hernia was one of gradual formation, and at the time it came under observation had descended into the scrotum of the right side. It was about the size of a child's head, and was acutely inflamed, although there were no signs of strangulation. An operation was performed, opening an abscess of the scrotum. On further search, the vermiform appendix was found, and was removed in spite of firm adhesions. The patient recovered.

In relation to hernia of the large intestine, the conclusions of Tuffier are of interest. He states that though congenital hernias of this nature may be without sac, peritoneal investment is found in all ruptures of slow formation. It is true that cases are reported where a sac has been absent, but none of these will stand careful study.

Gangolphe wishes, by his paper, to draw attention to the fact that appendicitis may occur in the sac of a hernia; that this will be indicated by inflammatory phenomena, together with suppuration, but without symptoms of strangulation; that operation is exceedingly difficult, on account of the firm adhesions, and that incision, if colotomy is determined upon, should generally be made upon the anterior inner surface of the tumor, since thus the danger of wounding the large intestine is lessened.—*Therapeutic Gazette*, March 15, 1892.

Selections and Abstracts.

EARLY EXPULSION OF THE PLACENTA.

If there be danger to the child in forcing an early expulsion of the placenta, the danger to the mother is equally as great, and probably greater. The practice is almost certain to cause a retention of portions of the secundines, which worry and fret the uterus, causing prolonged post-partum pains, frequently post-partum hemorrhage, and various other dangerous puerperal accidents, such as metritis, peritonitis, septicæmia, etc.

The conclusion of the whole matter is, that unless there be some positive indications for interference, such as post-partum hemorrhage, the physician should wait until spontaneous retraction of the uterus has expelled the placenta into the vagina before making attempts to deliver it. It may then be extracted without fear of injurious consequences.

When physicians generally learn this valuable lesson, post-partum complications, tardy puerperal convalescence, and cases of chronic invalidism, resulting from mismanagement of the third stage of labor, will be much rarer than at the present time.—*F. C. Ferguson, in Indiana Medical Journal.—Nash. Journal of Med. and Surg., Apr. 1892, p. 176.*

AMENORRHŒA OF SCHOOL GIRLS.

Dr. T. A. Reamy, (*Cincinnati Lancet-Clinic*), in discussing the amenorrhœa in anæmia, common to school girls, says: (1) She must leave school, and must not even study at home. (2) She must spend several hours each day in the open air, either walking or riding. In winter she must, of course, be warmly clad, but must wear no sheepskins or other chest-protecting pads. Standing in the open air, she must be induced to breathe deeply with the mouth closed; this should be done for at least fifteen or twenty minutes, and be repeated at least twice a day. Nothing that can be done will more

rapidly improve the character of her blood. (3) She must sponge her extremities and body each morning on arising from bed. The water must be of the temperature of the room, and she must practice freely with an ordinary towel. (4) See must drink plenty of milk and eat plenty of beefsteak. (5) She must take small doses of iron, combined with some bitter tonic, three times a day. Improvement may be somewhat slow, but if this course is faithfully carried out, a perfect cure will result, and her education may then be finished. If this course or its equivalent be not followed, the cases will go from bad to worse, and finally die from pulmonary tuberculosis.—*Southern Practitioner.*

THE SPREAD OF SYPHILIS BY CIGARS.

The writer reports the cases of two girls with distinct syphilitic lesions, who were employed in cigar factories, as "finishers." They used to bite off the ends of the cigar wrappers, using the saliva to shape the tips. Gottheil calls attention to the manifest dangers in this process. He is not aware that specific disease has actually been communicated in this way. It is possible that the tobacco leaf and tobacco juice in the mouth may render the contagious element innocuous. But it is also possible that the long period of incubation of syphilis has rendered it impossible to trace a source of contagion so unnoticeable. It remains a fact that upon every single cigar tip of the thousands finished by these two operatives, there was probably deposited a portion of the virus of the disease. Moreover, the practice of using the teeth and saliva in the manufacture of an article which is destined to be taken into the mouth is not without serious objections entirely apart from considerations of disease.

It will probably be impossible in the future, as it has been in the past, to stop this unclean and dangerous method of cigarmaking by pressure put on the operatives themselves. The saving time and trouble is so great as to outweigh every other consideration.—*W. S. Gottheil in N. Y. Med. Jour.*, Mar. 19.—*Epitome of Medicine.*

Editorial.

THE GEORGIA MEDICAL ASSOCIATION.

The forty-third annual session of the Medical Association of Georgia was held in Columbus, April 20th, 21st and 22d. The meeting proved the most successful in the entire history of the organization, over two hundred members being present, with an addition of sixty-one new members.

A large number of very interesting papers were read, which were ably discussed.

Columbus deserves much credit for the manner in which her guests were entertained. On the evening of the 21st an elegant banquet was tendered the visiting doctors at the Rankin House by the physicians and citizens of Columbus. The menu was most delicious and the responses to the several toasts quite happy. Following is the order in which they came:

The Medical Association of Georgia—Dr. T. M. McIntosh.
Woman—Dr. W. F. Westmoreland.
The Law—Hon. Lionel C. Levy.
The Press—Col. B. H. Richardson.
Practice of Medicine—Dr. Seth N. Jordan.
Our Past Presidents—Dr. A.W. Griggs.
The City of Columbus—Mayor J. J. Slade.
The Country Doctor—Dr. Frank Ridley.
Medicine as a Science—Dr. J. McFadden Gaston.

Being crowded for space we are permitted to publish only one of the toasts in this issue, but some of the others will follow at a subsequent date. We present in part the response of Dr. W. F. Westmoreland, of Atlanta, whose subject was

WOMAN.

"Here's to her health
Whose heart is wealth
Whose lips life's loveliest flower;
Whose cheeks are fair
As lilies are
Beneath the gentle shower."

Oh, woman, woman, what a part you play in our lives! What a trust we should have in thee! Even God showed the infinite trust he placed in you, when he conferred on you the divine obligation of perpetuating those made after his own image.

We cannot speak of woman without thinking of the associations of love by which our lives are bound to them from the beginning to the end.

Among the earliest recollections of our life, none of us will ever forget the tender eyes loved so well, that looked into ours with an expression of infinite love and sympathy. This was in our childhood's happy day, when with loving care she guided our tottering footsteps. How blest we have been rendered by that love. And the beautiful flowers of affection she planted along the pathway of our lives, are the brightest ones we gather into a wreath as we approach our journey's end. As we grow older, as we approach manhood's estate, another love comes into our lives, and the protecting love of the past is overshadowed by another, for the inspirations of the heart are alike everywhere. You forget that nothing will ever come into your life any truer or more honest than the regard, interest and love which a mother feels for you.

Now begins the Spring day of life, the day when we realize that we have found the woman that we wish to be everything to us—friend, comrade, counsellor, guide, sweetheart, wife—the one thing we think absolutely necessary to our existence. This is the love which is the flower of youth. These are the days of happy anticipation to be crowned by the sweetest realization. These days when we can see her, hear her voice, and touch her hand, our hearts have a feeling of perfect content and the world seems flooded with sunshine.

The sunshine seems so warm and caressing, the sky so divinely blue, the violets so purple and sweet.

We wonder if it is the day that is so divine.

Ah! love is a heavenly blessing, for a thing so perfect and ennobling must be like the beauties of nature, God's handiwork.

But then the scene changes and we reach that age where

we are just as dependent upon their mercy now as we were upon their love in the tender days of youth.

These are the days when we sit on the opposite side of the hearth, and as we look into each other's eyes we realize that the pallor of evening twilight, instead of the morning of the beautiful day of the past is dawning upon us.

But then there may be a different aspect—she may have passed away from the scene, but after all, I should think that the tenderest faith to devote your life to, would be memories which had so entwined themselves around your heart-strings, that after the acute pain of the lost had died away (with the lapse of time), your whole idea would be living the life they would have wished, ever striving for higher things.

Then such memory vibrating through the heart, touching the trembling living strings in the tenderest manner, would recall the lingering memory of sweet sympathy given in the past, and that even now you feel extending beyond the grave. But after all, give me the living memory, the living association, even though it sometimes may be one-sided. Then when the path-way of life becomes dark and our footsteps tottering, I will recall the lines :

In the desert a fountain is springing,
In the wide waste there still is a tree,
And a bird in the solitude singing,
Which speaks to my spirit of thee.

THE DOCTOR VS. THE MINISTER.

The question which seems now to be agitating the medical press is the relations existing between the medical man and the minister of the gospel, and the attitude of each to the other.

All the discussion upon the matter seems to have been brought about by the presentation of the bill of a celebrated Brooklyn physician against the estate of a Catholic priest for services rendered, which the heirs protested upon the grounds that it was not customary with the profession to make charges for medical services rendered such persons.

Taking a retrospective view of the field, from time almost immemorial the members of the medical profession have had

no more potent enemy than has existed in the representatives of the sister profession. No class of people can be found who are more ready to give their sanction and endorsement to a quack measure or a patent nostrum than they, whose signature to a testimonial glowing with enthusiasm and unreserved commendation carries with it so much weight upon the mind of the laity.

The quack nostrum vendor and the patent medicine manufacturer realizes to its fullest extent the truthfulness of this latter remark, and the natural outcome of such a status of affairs is that the secular press of to-day is teeming with testimonials of the wonderful and miraculous powers possessed by some certain patent medicine in curing some self-diagnosed disease which, in all probability, never existed at all, and attached to them are the signatures of Rev. Mr. ———, and Dr. ———, pastor of ——— church, and Bishop ———, etc.

These men, who are presumed to be the shepherds of their flocks, who are supposed to be the friends of weak and wayward mankind, and who claim to be men of learning and scientific attainments, are to-day completely ignoring legitimate medicine based upon centuries of diligent research and scientific investigation, and thus pouring dollars into the coffers of the sharp and keen-witted manufacturers of these goods; and "'tis true—and pity 'tis 'tis true"—*in some cases actually owning stock in the manufacture of the very nostrum they are so assiduous in advertising.*

Now, let one of these be stricken with some serious illness—one who has been most ardent in his endeavors to proclaim to the world (prompted, of course, by a deep and burning love for poor suffering humanity) the merits of some nostrum which he has found a panacea for every ill to which human flesh is heir. Does he send for the learned "doctor" whose name this preparation bears, or for a bottle of this "wonderful discovery?" We challenge the world for the citation of a single instance. The physician, the humble slave at the throne of Æsculapius, the martyr to his countrymen, the elegant gentleman and professional scholar, and the man whom he has made so desperate an attempt to

overthrow, is the one who is summoned, and yet, he not only receives, but expects these services free of all charge.

Section 3, Article I, Chapter III of the code says: "There is no profession by the members of which eleemosynary services are more liberally dispensed than the medical, but justice requires that some limit should be placed to the performance of such good offices. Poverty, professional brotherhood and certain of the public duties referred to in the first section of this article, should always be recognized as presenting valid claims for gratuitous services; but neither * * * * * * *nor any profession or occupation can be admitted to possess such privilege.*"

In what does their claim for exemption from fees exist, and why should they, because of their calling simply, demand and receive attendance upon themselves and their families gratuitously?

THE CENTRAL RAILROAD SURGEONS' ASSOCIATION OF GEORGIA.

The Central Railroad Surgeons' Association held their annual meeting in Columbus, April 19th.

The President, Dr. Seth N. Jordan, of Columbus, called the meeting to order and received the association in a few words of cordial welcome. The roll call showed that thirty-four members were present. After the minutes of last year's meeting had been read and confirmed, the program was carried out, with the exception that the essay on Anæsthetics, which was to have been read by Dr. Howard J. Williams, of Macon, was omitted, as Dr. Williams was unable to attend the convention.

Dr. W. H. Elliott, the chief surgeon of the Central system, was the first speaker introduced to the audience. He delivered a most interesting address on railway surgery, during which he treated in a very instructive way the relative merits of chloroform and ether.

Dr. S. N. Jordan followed Dr. Elliott in an interesting talk on when to operate.

Dr. A. C. North read a paper on his experiences in the treatment of railway injuries.

Dr. C. H. Richardson followed with a paper on Antiseptics in Railway Surgery. (See p. 268.)

The election of officers for the ensuing year was announced. The election resulted in the choice of: Dr. A. C. North, President; Dr. E. A. Perkins, Vice-President; Dr. H. B. McMaster, Secretary.

A committee on constitution was then appointed as follows: Dr. R. H. Taylor, of Griffin; Dr. N. G. England, of Cedartown; Dr. C. H. Richardson, of Montezuma.

The secretary requested the names of the surgeons who intended being present at the meeting of National Railway Surgeons' Association, which will be held at Old Point Comfort, the latter part of May. The following names were handed in: W. L. Felts, G. A. Bunch, J. S. Beard, J. P. Roblins, H. R. Mooney, R M. Butts, W. H. Philpot, W. B. Nott, T. E. Jenning, A. C. North.

The meeting then adjourned for the year.

AMERICAN ACADEMY OF MEDICINE.

PRELIMINARY PROGRAM.

The following topics are promised for discussion at the seventeenth annual meeting of the American Academy of Medicine at the Cadillac Hotel, Detroit, Mich., on Saturday, June 4, and Monday, June 6, 1892:

1. "Essentials and Non-Essentials in Medical Education," the address of the retiring President, Dr. P. S. Conner, of Cincinnati.

2. "The Value of the General Preparatory Training Afforded by the College as Compared with the Special Preparatory Work Suggested by the Medical School in the Preliminary Education of the Physician," a paper by Dr. T. F. Moses, of Urbana, O.

3. "Does a Classical Course Enable a Student to Shorten the Period of Professional Study?" a paper by Dr. V. C. Vaughan, of Ann Arbor, Mich.

4. "The Value of Collegiate Degrees as an Evidence of Fitness for the Study of Medicine," a paper by Dr. L. H. Menter, of Chicago.

5. "The Value of Academical Training Preparatory to the Study of Medicine," a symposium by Drs. H. B. Allyn, of Philadelphia; W. D. Bidwell, of Washington; and Egbert Wing, of Chicago.

6. "The Newer Medical Education in the United States," a symposium by Drs. W. J. Herdman, of Ann Arbor; Charles Jewett, of Brooklyn; and Egbert Wing, of Chicago.

7. A paper on "Some Phases of the State Supervision of the Practice of Medicine," by Perry H. Millard, of St. Paul.

Some other papers are partially promised, and the usual reports may be expected from the committees.

Members of the profession are cordially invited to be present at the sessions of the Academy.

AMERICAN MEDICAL ASSOCIATION.

The American Medical Association meets in the city of Chicago on the 7th to the 10th of June, and matters of great practical interest to the profession will come before this meeting.

The several sections will each hold two sessions a day for scientific work, while there is but one session daily of the whole body for hearing the general addresses and the transaction of business.

Dr. J. McFadden Gaston of this city is the chairman of the section of Surgery and Anatomy and his opening address will be upon "Surgery of the gall-bladder and ducts." This will be followed by other papers on gall-bladder surgery, with a discussion of them by those who are familiar with the subject.

The contributions on intestinal and abdominal surgery, with their discussions, will occupy the second day, and the third and fourth days will be taken up with miscellaneous papers on a variety of subjects of great practical interest.

There are already in the hands of the secretary of the surgical section, Dr. F. W. Mason, of Detroit, about forty titles of papers to be introduced into the program, which will be soon announced through the Journal of the American Medical Association.

It is understood that the committee upon improvement of the sections will meet in the city of Detroit on June 6th, the day prior to the opening of the Association.

Special Notes.

SANDERS & SONS' EUCALYPTOL EXTRACT (EUCALYPTOL). Whenever mention is made of "Oil of Eucalyptus" we beg you to bear in mind that such reference applies to our preparation, styled for distinction, "Eucalypti Extract (Eucalyptol.)" To avoid disappointment we would suggest to specify, when prescribing, our manufacture. Samples gratis through Dr. Sander, Dillon, Iowa. Meyer Bros. Drug Co., St. Louis, Mo., Sole Agents.

ADVERTISING.—If you wish to advertise anything anywhere at any time write to Geo. P. Rowell & Co., No. 10 Spruce St., New York.

We desire to call attention to the advertisement of Dermatol, a basic gallate of bismuth, which is coming into very general use as an antiseptic powder and a substitute for iodoform, the objections to the latter being its well known poisonous properties and the disagreeable smell accompanying its use. Dermatol has proven itself to be a non-irritating, non-poisonous drug, large doses having been given to dogs, introduced beneath the skin, and even into the peritoneal cavity, all without any poisonous effect.

IMPORTANT NOTICE AND REMOVAL.—To avoid failure or doubtful success in use of Peroxide of Hydrogen, be sure you get Marchand's Medicinal; no substitute can replace it, statements of dealers, interested or unscrupulous parties to the contrary notwithstanding. There is great inducement to substitute in this article, for the reason that Peroxide made for bleaching and varying trade purposes costs to produce only a fraction of what Marchand's Medicinal costs, and the unscrupulous druggist or dealer pockets the difference in profit at the expense of the physician's reputation for skill and Marchand's Peroxide of Hydrogen Medicinal.

Put up in 4 ounce 8 ounce and 16 ounce bottles only, with which every careful physician should be familiar in order to frustrate dishonest substitution and assure success in practice.

DREVET MANUFACTURING CO.,
28 Prince Street, New York.

We desire to call the attention of our readers to the new advertisement of Reed & Carnrick, on page 2.

This firm have spared neither labor or expense to perfect their Infant Foods in keeping qualities by sterilization and

A VEGETABLE ALTERATIVE AND TONIC

Verrhus Clemiana

CAUSES THE ELIMINATION OF SPECIFIC BLOOD POISON, the repair of wasted and disorganized tissues, and the restoration of the vital forces to their normal activity. In the treatment of Syphilis it supercedes the use of both Mercury and Iodide of Potassium, and is a reliable remedy for the evil effects produced by the excessive use of these drugs. It is also specially indicated in all Scrofulous Affections, and is invaluable in the treatment of Eczema and other Skin Diseases, in Chronic Rheumatism, Old Chronic Ulcers, etc.

Formula.—Verrhus Clemiana is a Compound Fluid Extract of Clematis Erecta, Prinos Verticillatus, Fraxinus Americana and Rhus Glabrum, with ⅛ of one per cent. of Venanthic Acid, C. H_2 O_2.

Dose—A teaspoonful in water, gradually increased to a tablespoonful, three or four times daily.

ALTHOUGH our Verrhus Clemiana has been before the medical profession for only about two months– too short a time to be fully tested in the chronic diseases for the cure of which it is recommended—we have received quite a number of letters setting forth the flattering results already obtained. We submit the following extract as a sample :

"Tried your Verrhus Clemiana on patient with large ulcer on leg, using Ichthyol externally. Ulcer has healed, and lady quite well. Commenced treatment February 3d, two teaspoonful doses.

"Am using it in a very bad case of syphilis which had resisted everything I could think of. The large copper colored blotches are disappearing, ulcer on leg much better.

"L. W. WHITNEY, M. D.,
"112 West Madison St.

"Chicago, March 7th, 1862.

BEDFORD, PA., March 22nd, 1862.

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Gentlemen :—The bottle of Verrhus Clemiana received and used in a case of Chronic Blood Poison. It has produced remarkable results in restoring the vital forces. I would like to have two bottles more.

Will remit on receipt of bill.

Very truly yours,
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We will be exceedingly obliged to all physicians who will report their experience in the use of this medicine.

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by placing them in hermetically sealed containers. They claim that Lacto-Preparata, an all-milk food, for young infants, and Carnrick's Food, composed of half Lacto-Preparata and half dextrinized wheat, for use after six months of age, have now practically reached perfection in keeping qualities, and that they are the only infant foods in the market that will alone thoroughly nourish a child during the nursing period. Their Lacto-Preparata almost perfectly resembles human milk in character, composition and taste.

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We take great pleasure in commending to the profession "Vinolia" soap, having used it, and find it to be free from the many objectionable features found in some of the other soaps, such as an excess of soda and potash left in them. It is guaranteed to contain pure unchangeable cream, is non-irritating, does not shrivel nor extract the oil from the skin.

It is a matter of fact that many healthy men and women today owe it to the faithful use of the Hypophosphites of Lime and Soda, that they did not die of consumption years ago. See the excellent advertisement of McArthur's Syrup on page 34 of this issue and follow the excellent advice therein contained.

For the past year or two, I have been using Peacock's Bromides, with good success, and from my experience find it the most satisfactory of any of that class of preparations now on the market.

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Let your motto be **Not How Cheap** are the goods, **B Durable.**

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Of what value are Short Coils?

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Our Batteries are universally recommended as superior to the leading practitioners.

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FOR DISEAES OF WOMEN.

UR PRIVATE SANITARIUM for the treatment of Medical and Surgical Diseases of Women, will be open for the reception of patients

The building is large and handsome, and was constructed especially for the purpose for ich it is to be used The grounds, about five acres, are beautifully shaded and are very at-tive. The Rooms are all of good size, thoroughly ventilated, and each has an open grate, e closet, gas and electric bells, inside and out-side blinds, double hung sash transoms over doors.

The entire Building, except the Surgical Division, is handsomely carpeted and beau-lly furnished. Water closets, with hot and cold baths, on each floor; hot and cold water at ive different places in the halls.

NO WATER PIPES IN BED ROOMS.

e drainage is as near perfect as Sanitary science can make it The house-keeping will be in rge of a most Cultured and Experienced Lady, who is widely known for her excellence and erior merit in this particular. The CUISINE SHALL BE THE VERY BEST, and the s rvice in ry respect as good as it can be made.

A MATERNITY DEPARTMENT, where everything is as near ASEPTIC as possible, and in rge of nurses educated and trained especially for this purpose, is an especial feature of s Institution.

THE SURGICAL DEPARTMENT, under same roof but disconnected from the main building, as near ASEPTIC as it can be. We have a full corps of competent Physicians to assist us. resident Physician, with a cottage on the grounds, will be in constant attendance. Our rses are all ladies of education and training in their profession, most of them coming ect from the Woman's Hospital, New York.

Physicians sending us patients may rest assured that they will receive the best care and ention in every particular, and reports will be made every few days. Special rates will be de for the wives and daughters of Physicians and Clergymen.

For further information, terms, etc., address

DRS. HOLMES & DAVIS, Rome, Ga.

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LAXATIVE FOR CHILDREN.—

Stearns' Cascara Arom'c ½ fl. oz.
Essence of Peppermint 1 fl. dr.
Syr. Senna 3½ fl. oz.

Mix. Sig.: One to two teaspoonfuls at bedtime.

SUB-ACUTE BRONCHITIS.—

R Ammon. chloridi, oz. ss.
Potass. chlorat, dr. iss.
Mist. glyc. comp., oz. iv.

M. Sig. Teaspoonful four times a day.—*Ex.*

HEMORRHAGE IN TYPHOID FEVER.—

R Pulv. opii, gr. x.
Ergotinnine citrate, gr. 1-10.
Pulv. plumbi acetas, gr. x.

M. fiat cap. No. x. Sig. One every four hours, oftener if necessary.—*Ex.*

INFANTILE DIARRHŒA.—

R Aq. calcis, oz. vj.
Syr. rhei arom., oz. j.
Tr. opii camph., oz. ss.
Tr. cardem. co., oz. ss.

M. One teaspoonful often to children under one or two years, afflicted with sour stomach attended with diarrhœa, vomiting, etc.—*Memphis Med. Monthly.*

CHRONIC DIARRHŒA AND DYSENTERY.—

R Cupri sulph., gr. vj.
Myrrhæ, gr. xij.
Confect. roses, fl. dr. ij.

Fiat pil. No. xii. One every six hours.—*Ex.*

SUMMER DIARRHŒA.—For childrer one year of age:

R Zinci sulphocarbolat., gr. v.
Bismuth subnitr., gr. xv.
Pepsin saccharat, dr. ss.

M. Et. in chart. No. xv div. Sig. One powder every hour until stools become inodorous; then every two to four hours.—*Waugh, Times and Register.*

NEURALGIA.—

R Acetanilid, dr. iss.
Camphor monobro., gr. xviij.
Pulv. rhamnus pursh., gr. xij.
Pulv. zingiberis, gr. ix.

M. ft. chart. No. 18. Sig. One powder after meals. Attention should be paid to the hygiene of the patient. —*Ex.*

THE HOTEL BELMONT

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TO THE PROFESSION:

I have recently moved from the Winyah House to the HOTEL BELMONT, offering now increased advantages in building, location and surroundings.

Special Electric Railway connects the Hotel Belmont with the Railway Station and the City.

Several hundred acres of grounds and parks, sulpher and iron springs are included in the premises.

For particulars, address

KARL VON RUCK, M. D.

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—For the *Anæmia* of a young girl fifteen years of age, Prof. Da Costa prescribed:—

℞ Sodii arsenit., gr. ¼
Ferri sulphat., gr. ij
Potassii carbonat., gr. ij.

M. One pill three t mes a day, the dose to be gradually increased.

Also a diet of fresh animal food, with green vegetables by forced feeding (four or five meals in the twenty-four hours), or if quantity is an objection, the freshly extracted juices of meat may be given. Red wines might also be given with advantage; and the patient should lead an outdoor life.—*Ex.*

FOR DIARRHŒA.—

℞ Tinct. opii camph., f oz. j
Misturæ cretæ, f oz. iij
Ol menthæ pip., mx.

M. A teaspoonful for an adult every three or four hours until diarrhœa is checked.

INFANTILE SYPHILIS—.

R. Protiodide of mercury, gr. iij;
Lactate of iron, gr. viij;
Powdered sugar, dr. ij.

To be made into ten powders, one of which is given three times a day. —*L' Union Medicale*, No. 12, 1892.

INJECTION FOR CHRONIC CYSTITIS.—

Ultzmann recommends the following prescriptions in the treatment of this troublesome condition:

Crystallized carbolic acid, gr. xv;
Distilled water, oz. iiss.

Dissolve, and mix with equal parts of hot water at the moment that the liquid is to be injected.

Or the following:

Boric acid, oz. ss;
Glycerin, oz i;
Distilled water, oz. x.

Make a solution, and mix with equal parts of warm water at the moment of employment.

Either one of these solutions when warm may be used for washing out the bladder in cases of chronic cystitis. When the vesical secretion is catarrhal and has a bad odor, the following injection is useful:

R. Nitrite of amyl, gtt. v;
Distilled water, oz. iv.

Mix, and add a tablespoon of this solution in the quanity of water for a vesical injection

TERRALINE

A Purified Preparation of CRUDE PETROLEUM for Internal Use.

A Substitute for Cod Liver Oil and Kindred Compounds. An Invaluable Agent in the Treatment of

Phthisis Pulmonalis, Tuberculosis, Catarrh, Cough, Scrofula, Chlorosis, General Debility, Etc.

It promptly allays the extreme pulmonary irritations, improves the appetite and overcomes the indifference and distaste for food, increases the weight of the body and begets a sense of comfort not exhibited by any of the noted remedies given in such cases.

It is put up in plain twelve ounce bottles and is sold only on prescription of the physician, it being strictly confined to the medical profession, by whom it is highly recommended for its therapeutic qualities.

Does not deteriorate with age, as do emulsions of all kinds, but is always fresh and pure, and ready for use.

The dose is small (one or two teaspoonfuls), and therefore it possesses the merit of being inexpensive as well as efficacious, besides is palatable and easy to take, and does not cause eructations or nausea, but is quickly digested by the most delicate stomach.

Here, at the National Capital, it is prescribed by the *entire profession*, with that certainty of result not obtained by any other remedy. By permission we refer to a few of our leading practitioners who use it liberally: Dr. Z. T. Sowers, Dr. James T. Young, Dr. J. O. Stanton, Dr. Byrd Harrison, Dr. Ralph Walsh, Dr. J. P. Murphy, Dr. D. C. Patterson, Dr. H. D. Fry, Dr. D. P. Wolhauptu, Dr. Franzonia, Dr. Sprigg, Dr. Harrison Crook, Dr. Bayne, Dr. Hazen, Dr. Brummell, Dr. Johnson.

R. Terraline. . . . . oz. xii.

Sig, One or two teaspoonfuls three or four times daily, in sherry wine.

The price of **TERRALINE** is One Dollar a bottle. A full size bottle for trial will be sent, charges prepaid, to any physician east of the Rocky Mountains, on receipt of fifty cents. Literature on the subject will be mailed free.

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Southern Medical Record.

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

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Original Articles.

THE PRESENT STATUS OF OBSTETRICS AND GYNÆCOLOGY.*

BY CHAUNCEY D. PALMER, M. D, CINCINNATI, OHIO.

In 1878, I delivered the annual address of the Alumnial Association of the Medical College of Ohio, on the subject of "The Present Status of Gynæcology and its Relations to General Medicine." This was nearly fifteen years since. It has occurred to me that there is no subject for me better adapted to a society of this kind, composed of gentlemen of almost all ages and specialties of medicine, of the great State of Ohio, than this very same one.

What is the present status of obstetrics and gynæcology to-day? No one will for a moment say that it is what it was fifteen years since. What it will be fifteen years from now, is only a matter of speculation.

To the thoughtful inquirer, it is plain that the relation of obstetrics and gynæcology to general medicine is a most intimate and inseparable one. The idea that a physician may practice gynæcology in its exclusive sense, without a knowledge of the diseases of the body at large, or with a

*Read before the Ohio State Medical Society, in Cincinnati, May, 1892.

disregard of the general bodily conditions, is one of the most absurb and dangerous doctrines. There is comparatively little gynæcology outside of the domain of general medicine; on the other hand, there is scarcely a disease of the general system in the female, of any considerable importance or duration, which does not affect the circulation, innervation, and functions of the pelvic organs. We venture the assertion, and challenge its successful contradiction, that no disease or class of diseases in the economy, set up more decided disturbances or complications at large than those of the female pelvic organs.

Medicine, although made up of parts, is really one. The whole stands by a linking together of all its parts; a separation of any link implies a break in the whole chain. Gynæcology has suffered not a little by this *exclusiviem* of our times. The extreme surgical tendency of some, has brought us an unmerited disrepute. Pelvic diseases must be learned by studying medicine in its entirety. Few constitutional diseases, or even local affections of distant organs of the body exist, that we do not see in women some peculiar expression of the same in the sexual system. The various states of a changed constitution of the blood, the so-called diathesis and cachexiæ, as anæmia. hydræmia, leucocythæmia, scrofula, phthisis, rheumatism, gout, syphilis, scorbutus, eczema, chronic malaria, almost invariably, unfortunately too rapidly, first disorder menstruation, and finally produce organic changes in the uterus. A neurotic habit, evidenced by attacks of general neuralgia, is accompanied by a neuralgic dysmenorrhœa, as is also such a constitution a very important factor in the causation of other pelvic affections.

Again pregnancy, more particularly the lying-in state, tests the soundness of a woman's constitution. Any imperfection of her system, any blood taint, although hidden, is apt to manifest itself at this time. Pelvic cellulitis, we have noticed, has at times an etiological constitutional factor. So has mammary inflammations, an enfeebled general health, a disease prior to marriage, present though latent. frequent child-bearing, prolonged and excessive lactation, and many other general causes make a woman liable to and perpetuate

sub-involution, hyperæmia of the uterus, with displacements, diseases and complications from which she would otherwise be exempt. Many of the well-known exciting causes utterly fail to bring about a local disease, without some constitutional morbific force operative in the background. In this way, a discovery of one's actual constitutional standard of health is revealed. Many of the chronic diseases of the uterus are chronic only in virtue of a diathetic taint—a general imperfection or depreciation of the general health. Therefore, that local diseases of the female pelvic organs require only a local treatment, is a pernicious doctrine, wrong in theory, dangerous and criminal in practice. A gynæcologist cannot be a skillful physician without a knowledge of medicine in general. It is necessary that he diagnosticate, know the causes and proper management of diseases in general. Constantly arising in his special practice, they influence and complicate the acute and chronic conditions for which his services are sought. In turn, while it is not to be expected of the general practitioner that he will differentiate uncommon and obscure pelvic affections, or perform special operations in this field of practice, it is expected that he will understand the importance and significance of symptoms here arising, and the general management of the diseases they express.

Volumes might be written on the influences of civilization and modern culture, with its fashionable surroundings and entanglements, modifying the diseases of women. Unquestionably, both sexes do not have a few of the physical ailments of a generation since, but it remains a seriously debatable question whether women now-days do not have many of their diseases more frequently. I believe they do, and look upon it as a penalty of our modern methods of living.

Local medication of the uterus is certainly better understood now than it was fifteen years since. There can be no question as to the propriety of local treatments, but an ailing woman, afflicted with a disease of her sex, must be at the mercy of the good judgment of an honest physician.

When to medicate, *when not* to medicate the uterus, *how*

often and *with what*, are questions to be answered by a studious, progressive practitioner.

Fluid applications to the uterus have now a diminished field of utility. Intra-uterine medication can be made less painful, less hazardous, and more efficient. Potential cauterization of the uterus is now much less frequently employed, and the use of the inevitable *nitrate* has almost become a relic of the past. Who can doubt that we better know how to treat endometrial affections than we did? That the endometrium is rather a glandular than a mucous tissue, is recognized.

Gonnorrhœa, it matters not how contracted, as a causative factor in many female pelvic diseases, has a hitherto unrecognized significance. Massage, as a therapeutic agent in gynæcology, is well appreciated, to say naught about the local massage after *thure brandt*. Electricity as a therapeutic agent, never received such attention. *Apostoli* has been, and is an enthusiastic, painstaking, and progressive worker. His enunciations have been seconded by careful, observing men all over the world, and he is considered to be not altogether a misguiding leader. Competent judges in gynæcology say we must use careful judgment and fair discretion in the selection of cases, *in kind*, if we do good with electricity for fibroids of the uterus. There is really no contention between electricity and surgery, in gynæcology. Each has its place and field of application, hence, usefulness. The *Apostoli* treatment for uterine fibroids, embraces by no means all the good we have in this line of practice. Unmistakable benefits accrue from electrical treatments in certain conditions of chronic pelvic inflammatory exudations, uterine versions and flexions, as well as for some of the various forms of uterine inflammations. We know comparatively little more concerning pelvic cellulitis and pelvic peritonitis than have been so clearly and reliably announced by *Bernutz* and *Goupil* in 1857. But our acquaintance with the diagnosis and operative cure of diseases of Fallopian tubes, is only of rather recent date. The gynæcological world had its craze of cervical splitting, then its trachelorraphy craze, its pessary craze, and now it is having its Fallopian craze.

A more clear and thorough elucidation of the diagnostic signs of pregnancy, intra and extra, have occurred in recent years. A recognition of early pregnancy depends, usually, not on one symptom or group of symptoms, but on a painstaking analysis of the sum total of evidences in a given case. The most conclusive evidence is found within the pelvis, in the size, shape and consistency of the uterus and surroundings, no sign, but the collective evidences of all signs, being considered. Many mistakes in diagnosis of pregnancy are avoidably and unavoidably made. It is well always to suspect for ourselves the possible existence or co-existence of pregnancy in any female whom we are examining, if between ten and fifty-five.

One of the most important advances of medical and surgical gynæcology has been the recognition of bacteria in producing certain morbid processes. How many cases of endometritis and salpingitis we now know are septic in their origin? Consider the diminished and diminishing mortality rates in modern obstetric practice. One death in one-thousand cases of parturition in Paris, and none in as many cases in Preston Retreat, would have astonished our predecessors. So much for improved aseptic and antiseptic precautions! We have come to understand that sepsis, not traumatism, is the danger in all obstetrical and gynæcological operations. We know now how to employ the uterine curette, a most valuable instrument, calculated to supercede much intra-uterine medication, so that its ills may be reduced to a minimum. Pessaries, we are not, as yet, ready to dispense with, although their use has been judiciously, greatly abridged. Some hitherto regarded incurable uterine displacements have been made amenable to medical and surgical treatment. Certain surgical affections of women, as vesico-and recto-vaginal fistulæ, lacerations of the cervix uteri and vagina, and perineum, are recognized as preventable diseases, and their best treatments are prophylactic and immediate. Stitch-hole abcesses, abdominal herniæ and fæcal fistulæ can generally be avoided. The greatest improvements in modern surgical gynæcology and obstetrics, prophylactic, plastic and abdominal, we owe to *Semmelweis* and *Lister*. A greater rev-

olution in political history, anywhere, at any time, never occurred, than these men have been the agents of originating in surgery.

The better methods of perineal repair, together with all the plastic operations to correct the injuries of pelvic structures from parturition, have been developed, if not perfected, within a few years.

In no direction has gynæcology grown in recent years, as in the surgical. Compare the most excellent work of *Greig Smith* of to-day with the gynæcology in surgery of 1856.

In 1855, *Spencer Wells* published a small book on the diagnosis and surgical treatment of abdominal tumors. "Is ovariotomy justifiable?" was the question then. Now everyone advocates its justifiability, and early. In recognition of the grand work which has been done for this otherwise incurable disease, witness the operations of the liver, gall bladder, stomach, spleen, kidneys, intestines and other abdominal and and pelvic structures. Section, peritoneal irrigation, and drainage, have revolutionized abdominal and pelvic surgery. It is impossible to practice gynæcology without a resort to surgical procedures. Such is the causation and nature of many of the gynæcological diseases that surgical operations for them is a *sine qua non*. Modern gynæcology has made its most wonderful advance by surgery. See what it has done for extra-uterine gestation, uterine cancer, some kinds of uterine displacements, and otherwise unrelieved uterine fibroids. Not only has vaginal hysterectomy established for it a proper place, but through supra-vaginal hysterectomy, is destined to be the operation, if any, for uterine contain, not all uterine fibroids. No real contest between high amputation and complete vaginal hysterectomy for uterine cancer exists.

More than my allotted time has been consumed in praise of what gynæcology *has* done and *will* do; and many pages might be written concerning modern gynæcological abuses. Every department of medicine and surgery has been subject to abuses. Intra-uterine medications, the *Emmett* operation of trachelorraphy, the *Sims'* operation of cervical incisions, the *Battey's* operation of oophorectomy, and not a few operations

by laparotomy, and vaginal hysterectomy, have each and all been abused. No intelligent, rational physician will, for a moment, attempt to assert that these surgical procedures have no place in practice, and should be ignored. It would be well if every medical man would carefully consider the supposed curative effect of operations *per se*. Medical records are full of them. The physical influences at work are, at times, a most interesting study. The influences of the body, especially the pelvic organs of females, on the mind, are ever to be held in view. We should ever endeavor to avoid developing a neurosis, through intra-spection, especially in mobile patients. I would discountenance the removal of the uterine appendages for mental disturbances of any kind, for all cases of hysteria, most cases of hystero-epilepsy, dysmenorrhœa, and many cases of neurotic pelvic pains; at least, they should be done if at all only as a last resort, and only after full consent and explanation to patient and her family of results expected.

The modern tendency of to-day is to make many of the female pelvic operations on a very small pretext—made unnecessarily, it may be, either for life, comfort, or the preservation of health. Many of the well recognized failures of oophorectomy and salpingo-oophorectomy have followed operations done for hystero-neuroses, under a mistaken diagnosis.

Notwithstanding all the draw-backs and abuses gynæcology has encountered, the young science and art applied have relieved many a useful life and saved from the grave many a worthy, noble companion for life, otherwise unhelped.

TREATMENT OF TAPE-WORM.—According to *L'Union Medicale*, Crequy recommends the following capsules for the treatment of tape-worm:

R Oleoresin of male fern, dr. ii
Calomel, gr. v.

This is to be divided into sixteen capsules. Early in the morning one of these is to be taken every five minutes with a tablespoonful of sweetened water. As a general rule, the tape-worm is swept out a few minutes after the injection of of the last capsule.—*Therapeutic Gazette.*

THE INFLUENCE OF CIVILIZATION AND SOCIAL LIFE UPON WOMEN, AS VIEWED FROM A MEDICAL STANDPOINT.*

BY D. C. HURT, M. D., COLUMBUS, GA.

Amid all the changes which are taking place in the physical world, human life bears its portion. Whether it be called evolution or change consequent upon improvement or disintegration of human blood and human life, the changes are manifest.

In the science and art of medicine and surgery, great and wonderful strides mark our present era. Whether, therefore, some changes we now discover and attribute to diseases alone may or may not be the outcroppings of inherent or acquired malnutrition, remains yet to be explained. Looking back over the history of our science for the past ages, we find that despite the real changes there are many that are imaginary and dependent upon the fashions of men's mind and reasoning.

Somewhere and somehow there has grown in the human life of females that element of temperament and disposition which brings about more or less of disease destructive to human happiness. While in the present day so much attention is being paid to the diseases peculiar to women, it is highly proper that we, as medical men, should dwell with serious thoughts upon the causes and conditions that bring about these results. It is the office of the physician to assidiously apply himself first, to preventing and, secondly, to removing as far as possible all maladies that this human flesh is heir to, but when we open our eyes fully to the condition of 30 per cent. of our women of the present day, the facts stare us in the face that these evils are wonderfully multiplied.

There is a law of our physical being under which we are created, by which our bodies are to be governed for the preservation of health, the maintenance of life and the propagation of our race. What we mean by this law or its application is where not only one organ performs its legitimate function, but where all work together in one harmonious manner. The

*Read before the Medical Association of Georgia, April, 1892.

infringments upon these laws are surely followed by deleterious effects upon the violators. The most sensitive constitutions and the most delicate organs of that constitution are those which yield first to the penalties thus inflicted. We find, therefore, that the female constitution being differently formed, is increased in its nervous sensibilities and thereby more readily yields to such influences as ignore these laws. We find also that the habits of women as we advance in civilization and society life bring them directly to ignore these fundamental laws to such an extent as to create physical deformities and break down their nervous constitution. The fruits of these violations are everywhere manifest, from the slightest degree of nervous disturbance to that giant form insanity, from the most trifling disturbance of the generative system to the most incorrigible and death-dealing contamination of that nature which distinguishes her sex.

Gynæcology existed in the dark ages of medicine, and truly but little was known and less demanded on that line until within our present century. It will not do for us to assume the false argument in this case that, then ignorance was bliss and it was folly to be wise.

A practical demonstration exists to-day by comparison of our savage and civilized women of America. While the Indian squaw is unacquainted with female diseases and broken down constitutions on account thereof, our cultivated and civilized women are growing more and more intolerant of that life which pertains to their special duties as females. The Indian squaw lives in her hut and performs manual duties and undergoes hard physical labor without any interference with her female nature and to her the act of parturation is looked upon without dread, carries with it but little pain and scarcely interrupts her duties for one day. Our civilized and cultured women, if forsooth they arrive at healthy womanhood and maturity, are liable at each turn of life to become a prey to some one or more of the thousand maladies that eventually brings them under the care of a gynæcologist. Why this change? What means the multitudes of sanitariums and hospitals for women which are wonderfully on the increase as far as civilization extends? What means this large per-

centage of our females that must be unsexed in order to extend their days? Shall we accept this as an argument against civilization, culture of mind and body and the study of arts and sciences?

The style of dress which exposes the body to the most inclement weather, producing reversions of cold and heat; waist being tightly laced by steels, the body is kept in such a state of contortion that deformities result and produces deleterious effects upon parturient women, as well as disturbs the function of the whole organism.

The pollution of mind which is developed from reading sensational novels too often beget a corruption of thoughts and desires which militate against these laws of nature and lead to practices and indulgences which drift farther and farther away from an obedience to nature's laws. As one of the outcroppings of such influences I may cite the case of murder which took place at the hands of a young woman a few months ago in the city of Memphis and which has been followed already by like cases. This girl was so infatuated with her love for her own sex as to conceive in her depraved mind the idea of being discarded by her. Again, the French writer Belo in his book "My Wife" relates the destruction of the happiness of two families by that strange infatuation of the love of one man's wife for the wife of another.

Having seen that woman was naturally endowed with physical constitution fitting her for all duties in her sphere and seeing that now it is with great difficulty she passes through the period of true womanhood without becoming a prey to some disease, we must assign a cause and if the cause or causes are rightly determined, then we, as medical men and guardians of life and health, ought not to leave undone anything that will aid in bringing succeeding generations back to nature's standard of health and vigor. Whether these duties require us to give attention to the physical, moral, mental and social care of the patient or all of these combined, we should be honest enough with ourselves and have consideration enough for humanity, and have pride enough in our profession to perform these duties well.

How are we in the habit of dealing with this question which

relates to the health and happiness of our females? If a lady calls at the office of a physician and he is satisfied after thorough inquiry into her history and her present condition, is he not too often content to make his prescription, accept his fee and tell his patient to call again in a few days, ignoring the fact that some good and wholesome advice pertaining to the management of her system and due care in her social habits, taking of proper food in proper quantities, retiring at healthful and systematic hours, would conduce more to restoring her health than would the prescription alone? In these days when parents are over-indulgent it is often the case that when a girl leaves the nursery with a depraved nervous system, vitiated appetite and a nature too highly sensitive to maintain health with her surroundings, she approaches puberty with her system already unfitted for functions yet to be established. She soon finds that her duties at school make her morose or irritable and that her mind is not capable of receiving readily the impressions sought, nor her body capable of enduring the fatigue made in search of them; she at once falls into the hands of a physician who finds already present depletion of the system, impoverished blood, nervous prostration, enfeebled digestion, constipation, amenorrhœa, etc. He begins with tonics, stopping the child from school and directing systematic exercise. He realizes the fact that to do his full duty in the case he must give the parents wholesome instructions depending upon the execution of which is the future welfare of the girl. In such a case as this the duties of prescribing and proscribing are each alike obligatory upon the physician who seeks to perform well his part as such; and the medical man who is well informed will have the satisfaction in after years of having dealt honestly with his patients.

Again, the girl who is about reaching puberty is rarely ever informed as to the care necessary when anticipating such an event in life, and often, by imprudence and ignorance combined, is at the very onset of womanhood, divested of health and invested with such diseases as entail lifelong suffering. In such cases the family physician will not be overstepping the bounds of propriety in advising the parents so that due caution may be exercised. For it is true that a large per cent. of the cases re-

sulting from such causes and which we denominate suppressio-mensium, emansio-mensium, are produced at this period of life. The patient falls into our hands emaciated and hysterical, pleading for relief. Up to this time the physician has done well by prescribing medicine and hygiene, but he now enters the field invaded by new diseases, induration, ovaritis, displacements, and menstrual disorders. It is at this point that the gynæcologist with his armamentarium appears upon the field and begins his work of investigation.

It is not my purpose in this article to discuss the diagnosis and treatment of diseases, but encourage such general oversight and management as shall prevent rather than cure.

Drawing again upon our comparison between the savage and civilized nations, we cannot deny the fact that the discovered cause or causes lay within the range of prevention. These causes as we have seen are exerted upon our females at every age of life, upon the child as she leaves the nursery, upon her again as she enters school, and again upon performing school duties in approaching the age of puberty; while she is a young lady devoting herself to society and society life. Upon proper care at these ages our girls may be brought up with a union of the physical, moral and mental forces so combined as to avoid many diseases and render her capable of happiness and entail the same upon the healthy offspring.

By way of disgression, here allow me to allude to our schools of the present day. After years of careful observation, I am fully persuaded that our system of education militates greatly against health and healthy development of our girls. I have observed as have many of you, the strain upon the nervous system caused by an improper lighting of the study room; as through the medium of the optic nerve so affected, the whole system is often disturbed; also the baneful influence of bad heating and ventilation of school rooms impairing digestion and the proper growth and development of the body. While my connection with these schools as trustee has led me to these observations, I am glad to say that more interest is taken now than ever before both by teachers and trustees looking to the remedying of these evils. A vast amount of literature written by men of experience is being disseminated

throughout the entire school system of this country, which promises to be productive of much good to future generations. Again, for the past three decades, it is a fact in statistics that our Southern families are not as productive as before and there is a growing disposition to antagonize nature's laws so far as they relate to procreation. The small number of children found in New England fifty years ago showed a marked contrast with the birth rate of the English, Irish and German. I fear that the mania for exemption from this legitimate duty has infested our Southern women and they too are drifting into disease and decay on account thereof. The proud queen of England deserves much more honor to her Royal Highness in the fact that she brought forth, nursed and trained her own children and thus has placed before her subjects an example worthy of imitation. Could women be convinced that their lives were in jeopardy upon any deviation or violation of nature's laws, we would have much less need for our sanitariums and the practice of gynæcology.

Resuming, I repeat that prevention of such interference is at once the duty and triumph of our art; the striving after this end, the highest function of medicine. The subject for our protection, the culmination of man's happiness—the most lovable and attractive in true and healthy womanhood.

The time may have been when physcians, lacking in the present information that we have this day attained, not over crowded with work and exceedingly jealous in the profession, would have decried any efforts tending to these higher duties of life in the prevention of diseases; but in this age of our science we find those who are best informed the strongest advocates for the proper rearing and development of our physical nature, who concede the necessity of a due regard to the moral and mental culture as well. That physician succeeds best and grows most whose broad philanthropic mind divests him of narrow and contracted views and allows him to reach out for the greatest possibilities of good to humanity. Our object and aim in prosecuting our science should be to carefully guard every element of the human nature, that there may be a uniform and co-ordinate development of all our faculties. With this purpose steadily in

view and the practice constantly maintained, we would not be surprised that on the advent of the next century, forces and influences should be put in operation that would insure for succeeding generations heathfulness of mind and body, longevity and a re-establishment of that endowment to our nature which was originally given by an all-wise Creator.

Then let us begin that revolution which looks with all its combining influences and co-operative mediums to pulling down our hospitals, stamping out diseases and restoring our females to their wonted health, strength, and beauty. Let us, by wise counsel prudently given to parents, help them to govern their children, control their appetites to the use of proper diet, root out pernicious habits of dress, train their minds to digest healthful and enlightening literature, cultivate social and moral habits and thus ward off the miasmatic vices which are ever lurking just outside the nursery and seeking every opportunity to obtain its victim.

Let us call upon the co-operative efforts of those who have the custody of our schools and ask them to demand a strict observance to the rules of hygiene; to bear in mind the fact that the success of instructors depends very largely upon the maintenance of sound bodies in their pupils. Let us, as medical men, lose no opportunity as we come in daily contact with the people, to instill into their minds ideas on every line conducive to health. It is not improbable nor unreasonable for us to expect that ere the dawn of the 20th century our science shall be able to effectually stamp out many of the epidemics which now run rife over our towns and cities, often depopulating large families. It is not unreasonable for us to look for a Jenner or a Pasteur who shall save us from the ravages of yellow fever, diphtheria and a host of other ills that occasionally invade our land and country. With our present knowledge of antiseptics, we destroy those bacteria which lie broadcast about our homes, and arrest the germ-producing process already at work in the consumption of our bodies, and we should with equal dexterity and confidence in our skill, remove the cess pools of moral corruption and elevate the mind to higher functions and duties of life, making void the caverns of sin which pander to depraved appetites,

thereby guarding us against those depravities of our nature which tend to foster in us vitiated blood, whose domain it is to contaminate our whole being. We should guard our commonwealth against the concealed viper discovered only by medical men, which lies ever and anon in our pathway seeking anxiously every opportunity of injecting its venom into the moral and social veins of human life, thereby leaving in us or in our systems that poison which is to be handed to our posterity as a defiled inheritance.

We should warn the people to guard against a Nemesis which stands with uplifted dagger ready to plunge into our bodies and suddenly snatch us out of existence. Let us appeal to our various governments—municipal, State and national—to co-operate with us both by their moral and financial influence, that they may aid us in removing the lepers beyond the reach of contamination, and through their sanitary laws aid us in building bulwarks over which no invaders dare attempt an ascent.

Finally, let us hope that every man, woman and child shall be so invested with the love of purity of life and all that is elevating, ennobling and refining, that sin and its votaries, which means but the pasture in which diseases are well-bred, shall find but a barren waste and perish thereon.

ABORTION IN AN HOUR.

BY CHARLES H. HARRIS, M. D., CEDARTOWN, GA.

The difficulties encountered in the treatment of abortion are so well known that is unnecessary to name them. The experienced physician has met with these cases in every stage of developement, from the neurotic prodromata to the emptying of the uterus and its subsequent involution. Mild forms of the accident rarely come under our observation as they transpire without exciting any alarm; women do not take their beds for them; indeed, it sometimes happens that they are themselves unconscious of their condition until they notice that "something has passed" from them.

As a rule, it is only the bad cases that call on us, such cases

as are attended with great suffering or danger. There is a reason for this tardiness on the part of the women in seeking our aid. Reduced to its last analysis it means our objectionable management of them. We do not please them in this line of practice. The older doctors are painfully aware of this fact. They call upon us for relief and we do what we can—perhaps tent the cervix and tampon the vagina and tell them to be patient, that in due time everything will happen all right, or if the case will admit of it, we rapidly dilate, curette and extract as best we can with the usual instruments. It is this dallying conservatism and rough handling with uncertain results, too well known to the women, that keep them aloof from us until they are driven in from the desperation of fear. Is it any wonder when we review the results of our work! The death roll and wrecks of womanhood along the line of our march, justify their evasion of us, and we admire their wisdom. Along with their other attractions, the women have sense and they use it. Had we impressed them with our skill, things would have been different. Did they know that we could relieve them in a few moments or at most in an hour, we would gain their confidence, and the field of accidental abortion, as yet barely touched, would be fairly ours. That any case of abortion in which an operation is admissible, may be brought to a finish in an hour and on the first visit, I deem not only possible, but eminently practicable. If we find the cervix dilated or dilatable, a few minutes will suffice. Should we find it rigid, narrow and unyielding (a rare exception) it requires more time, patience and perseverance to overcome this difficulty—not however more than an hour. This contingency is met as we will directly understand by means similar to the obstetric forceps and the dilation goes on *pare passu* with the processes of detachment and expulsion. The instruments used are not forceps and dilators; they are combination curettes and snares made expressly for the operation and are adjustable in utero. They are of steel round-wire and flat stout watch-spring. With little difficulty they may be made to pass the cervix of any pregnant uterus and at the will of the operator project inside of the organ a curette or snare suited to the work. They are so

slender as to practically occupy no space at all since they become embedded in the mass of the ovum. Having observed the rules of antisepsis, the operator passes the smallest loop of snare number 1 fairly within the uterus. This done (with average skill) he should be master of the situation. If nervous, the patient should have been chloroformed and in Sims' position. His task now is almost purely mechanical, viz., to detach, chop up into small fragments and remove the ovum. This is done by curetting and snaring. Curetting requires small loops of wire and should be thorough and rapid. Snare No. 1 having been passed into the cavity of the uterus, its loop is now enlarged an inch (twice the size of the thumb nail) and the instrument is urged on to its work of destruction. The attachments of the placenta are rapidly severed and the staff of the snare made to sweep around the globe of the ovum. To make assurance doubly sure, enlarge the loop another inch and scrape the uterus as you would a mortar with a thin spatula. Should the membranes survive this ordeal, they should now be ruptured. Draw the wires back through the staff so as to make a loop at its terminal end in the uterus. Now aim the small loop towards the center of the ovum and plunge it into the mass. Failing in this, snare No. 2 with small loop should be passed into the uterus and the membranes are easily ruptured. A better instrument cannot be devised for this purpose.

An eminent gynæcologist says: "It is between a dull and sharp curette and will take the place of both in many operations." Having ruptured the membranes, the work of snaring begins. For snaring purposes, a large loop of round wire is best. A large loop of snare No. 1 is sprung in the uterus and is kept moving until it hangs upon the ovum. Now pull with forceps, movement and steadily increasing force. There will be several results from this traction; it is the best, surest and safest and quickest way of dilating the cervix. It is a perfect uterine tampon. It will either extract entire, or else divide the ovum reducing its bulk and avoiding the necessity of largely dilating the cervix. The finest results, however, from this traction is its remarkable effect on the uterus. Through reflex agencies beginning

in the cervix, contractions follow and we invoke the best efforts at expulsion. It is this vigorous co-operation of the uterus which stimulates so closely the typical abortion of a healthy woman. Should the wire cut its way through the structures of the ovum, it should be re-introduced and the snaring continued until mass in the utero is reduced to small fragments and extracted.

The snares have a traction power of over an hundred pounds, which is amply sufficient for the work. To complete the toilet of the uterus, snare No. 2 with flat watch-spring is passed with small loop, enlarge the loop until it presses well on the uterine wall. Pressing upwards the snare is rotated backwards and forwards on its terminal axis, until it works smoothly. This scrapes off the residual placenta, which with the detritus of the ovum is removed by passing the loop into and out of the uterus until the fragments cease to appear in it. It only remains to swab out the organ with a styptic antiseptic and irrigate the vagina with sterilized water. In this operation the surgeon does all the work. Nothing is left to nature or accident. It applies to the first three months of pregnancy, before the structures of the fœtus become toughened and hardened by ossification. The author is well-aware of the magnitude of the task he has undertaken. Reforms in medicine are slow, and when they assume the dignity of revolution, as in this operation, they are met with bristling opposition from every quarter. It has been our purpose to place the operation for abortion where it has never been, among the certainties of surgery. Along with this, we hope to capture a field of practice for the profession which as yet has barely been touched. A doctor will not permit a woman to remain in labor for days without relief, and it will be equally culpable when this operation is understood for him to allow a case of abortion to drag its weary course along through days and weeks, as heretofore More than this, he will be held accountable, if he does not relieve his case on the first visit.

Have used Peacock's Bromides in my practice for some time, and I would not like to be without it, in fact I do not know of anything that would take its place in nervous conditions. J. T. KILBURN, M. D., Trufant, Mich.

Correspondence.

NEW YORK LETTER.

NEW YORK, April 19, 1892.

Two papers were read last night by Drs. L. Duncan Bulkley and C. W. Allen before the Section of Public Hygiene at the New York Academy of Medicine on the frequency, contagiousness and prophylaxis of syphilis. Both papers were precisely of the same character and in them high colored and exaggerated views of the destructiveness of this disease were put forth by the authors. Statistics were read showing the great percentage with which syphilis prevailed in some countries of Europe, emphasizing its extreme prevalence in certain parts of Russia, Portugal and France, and calling attention to the legislative action its great frequency and contagiousness called forth. The authors suggested that similar legislation be applied to restrict the disease in this country where it was becoming more and more prevalent every year.

A number of well known syphilographers were present at the meeting and from the character of the discussion which followed, it was clear that the picture drawn by the authors of the two papers did not harmonize with their views of the destructiveness or frequency of this disease.

Dr. E. L. Keyes, who opened the discussion, ridiculed some of the views expressed therein and stated that in his opinion gonorrhœa and its complications killed more people than syphilis. The vast majority of people who acquire syphilis late in life do not seriously suffer from it, if in reasonable good health before acquiring it, and the disease does not materially affect their life, health and happiness. The bad cases are those who neglect its treatment, who drink excessively and have certain idiosyncrasies. The bad symptoms of the acquired form of syphilis are not due to the disease, but to the soil. He has seen several members of the same family who had acquired syphilis at different periods of life who developed a most malignant and vicious form of the disease,

while in the case of others it amounted to practically nothing. It was not in either case a good or a bad syphilis, but the soil in one instance was capable of producing luxurious fruit, and in the other none at all. There was no doubt in his mind that gonorrhœa ultimately kills more people than syphilis. It is more contagious, more insiduous, harder to detect, capable of stirring up a fresh gonorrhœal capacity and reproducing the contagion, ending finally in stricture, kidney disease and death. It destroys the population by producing salpyngitis and preventing conception. If legislation were to cover venereal disease at all, he thought they should carry it out so as to include gonorrhœa.

Dr. Sturgis also agreed with Dr. Keys as to the greater danger of gonorrhœa in its sequelæ than syphilis. With regard to legislation, there is nothing he knew which would stop syphilis, and the moment they attempted legislation to that end they would start such a hornets nest about their heads that they wished they had not made the attempt. He, the speaker, has told men who had disease, not to kiss their wives, and a few weeks later the wives came to his office with the same trouble. So it goes, and so it will continue to go till the end of time, and we cannot prevent it. All that can be done is to advise, but so far as the question of legislation was concerned, he believed it to be wholly powerless.

Last week a young woman with an exfoliative dermatitis presented herself at the skin class of the North Western Dispensary. The disease had lasted for a period of three months and the entire surface of the body from hair to toe nails was affected. The skin was reddened, the natural marking exaggerated and the whole body covered with large, semi-adherent epithelial scales, especially marked on the flexor aspect of the limbs. The patient was extremely neurotic, had marked hysterical attacks, and was peculiarly susceptible to arsenic, which is a specific in this affection. The arsenic was so badly borne in this case—an interesting feature of the malady—that five drop doses of Fowler's solution produced symptoms of poisoning. The treatment, therefore, had to be confined exclusively to external emollient applications.

A feature of the skin class of this same dispensary, is the

the large number of colored women who come with late secondary lesions of syphilis. Syphilis in the negro, like other skin affections, is hard to diagnosticate. The difficulty of diagnosis is due to the masking of the color by the dark hue of the patient's skin. The diagnosis is to be made on the shape and location of the lesion. It is generally in the form of a papular eruption confined to the face and head. It begins as a dark papule, spreads peripherically and leaves a deeply pigmented and slightly atrophied centre. The circles thus formed coalesce into large, gyrating figures.

In a paper on "Hydrotherapy," read before the New York Academy of Medicine, Dr. Wm. H. Draper sums up with the following conclusions:

(1.) In bath cures, the beneficial effects are due to the thermal qualities of the water, there being no evidence that absorption plays any part in it.

(2.) The chloride of sodium springs are chiefly useful for bathing and drinking purposes in anæmia and chronic rheumatism, and in disordered digestion; also, in nervous and chronic catarrhal affections.

(3.) That the alkaline and soda springs are mainly beneficial in gouty affections.

(4.) That the sulphur springs may be regarded as indifferent waters.

(5.) That the iron springs may prove useful in simple anæmia.

Dr. S. Baruch, in discussing the paper, said that the external use of water he considered to be one of the most potent remedies that we have to-day. A remedy to be useful must possess three qualities:

1. Its action must be explicable upon a rational basis; 2. It must be adaptable to exact dosage; 3. It must stand the test of clinical experience.

All these qualities are possessed by hydrotherapy. Its influence upon the nervous system by an excitation of the peripheral nerves, followed by a contraction or dilatation of the blood vessels, has been shown by experiments made by Dr. Max Schuller, who trephined a rabbit and exposed the pia mater. On putting a cold compress on the rabbit, the vessels

of the pia mater were seen to dilate, while, on the other hand, when a warm compress was used, the vessels contracted.

He, the speaker, has cured a number of desperate cases of insomnia by carrying out the idea shown in this experiment.

At the Montifore Home, in this city, they have succeeded in restoring to their families individuals who have been sent there from other hospitals to die, and who, by means of hydrotherapy have been restored to perfect health.

This treatment had not become popular owing to the prejudice of the people, and when the physician is wholly convinced of the value of this method, and understands how to apply it, this prejudice will be overcome.

OBSERVATIONS ABROAD.

THOMASVILLE, GA., May, 1892.

Editors Southern Medical Record—

A few observations while in Vienna recently may be of interest to your readers now. The statment is made there by Fenger, a genito-urinary specialist, that 43 per cent. of the sterilities is a fault in the male, and that 70 per cent. of this 43 is caused by gonorrhœa and its sequences, which he claims is never cured but exists in a latent form, capable of producing infection. The sterility is due to two conditions: asperma, when spermatozoa are absent; necro-sperma, when they are present, but dead. Asperma exists when from epididymitis or orchitis there is a permanent hypertrophy or a secondary atrophy of the testes, or when there is an inflammatory closure of the seminal ducts without orchitis or epididymitis.

In necro-sperma the sperm forming glands and ducts remain normal, but there is a secretion of pus, especially in the prostatic portion of the urethra. The normal reaction of the prostatic fluid is acid, due to phosphoric acid; the reaction of pus is alkaline. The spermatozoa normally do not manifest evidences of life, or have motion until they are immersed in the prostatic secretion, which in chronic gonorrhœa is alkaline by reason of the pus, and fails to vivify the semen, and thus the dead spermatozoa. These results of gonorrhœa in men will relieve many a woman from the fault

of sterility usually attributed to her, and take many patients from the hands of the gynæcologist who might be consulted because of sterile wedded life. However, that a gonorrhœa is never cured and retains indefinitely its power of infection, will not generally be accepted, for there is no anatomical or histological reason why a specific urethritis should remain uncured that would not apply to other mucous membranes specifically inflamed; and there is the greater one of every-day observation, that 80 per cent. or more of the men have a gonorrhœa before marriage, who beget children, and whose wives are healthy. There can be no doubt, however, that many men are sterile from the complications of gonorrhœa, producing permanent organic changes, and in this sense it is incurable. A number of years ago Noeggerath, then of New York, proclaimed as the etiology of all inflammations of the uterine mucous membranes and its appendages, a latent gonorrhœa. The opinion was so repugnant to the sentiment of the public and so contrary to views of established medical opinion and teaching, that he lost his practice and went to a little town in Germany. Now, any number of eminent authorities agree with him. Therefore, if the above is true as applied to both sexes, gonorrhœa is a very serious disease in both a clinical and social sense, and we must accept it as true in so far as we do have often serious and incurable complications of gonorrhœa in both sexes, though we do and must doubt the continual duration and infectious character, even though the microscope should find a gonococcus in ten or twenty years. If the gonococcus is pathognomonic of gonorrhœa, we can easier believe that frail humanity has "loved again, not wisely, but too often," and has a new infection, and that the disease has not existed for twenty years, latent and uncured.

Under the teaching of Dr. Grunfeld, who has written much on the subject, one becomes very much interested in the use of the endoscope in the diagnosis of diseased conditions of the mucous membrane of the male and female urethra, and convinced of its practical value in the treatment of same. I do not refer to cystoscopy, which requires electric light illu-

mination and an expensive apparatus difficult to keep in order.

In acute gonorrhœa, he uses the usual method of injection, and uses the endoscope chiefly to diagnose those conditions which produce discharges for such a time after the acute stage has passed as to warrant the term "chronic gonorrhœa." Just when the chronic gonorrhœa begins and the acute ends, he does not definitely say, but usually after six weeks duration he thinks it is chronic. However, he does not wait this long before the use of the endoscope, but may do so as soon as the acute condition of swelling and pain has gone. From an endoscopic standpoint he divides urethritis into simple, blenorrhagic, membranous, phlyctenula and ulcerative, which last includes the gumma and chancroid in the urethra. The conditions correspond in appearance and histologically to the same situated in other mucous membranes, a membranous, phlyctenula or granula conjunctivitis, or the so-called dry catarrh of the nose and throat or a mucous placque or gumma. Often following a blenorrhœic urethritis, there is a development of a granular condition of the urethral mucous membrane, which is best treated by the application of sulphate of copper, though not so often as in conjunctival granulation, because the epithelial regeneration is not so rapid in the urethra. Following this granulation is often the histological condition of atrophy of the mucous membrane, and the clinical one of dryness and an abnormally pale and glistening appearance. In addition to the atrophy of the mucous membrane, there may be the development of new tissue, (the fibrous tissue of stricture) and these are treated by the direct application of iodide potash and iodine, one part of each to sixty of glycerine. The ulcerations are treated as those of the same character would be elsewhere situated. Of course this treatment can be varied to suit the case and condition, and the preference of the physician. As an illustration of the diagnostic value of the instrument, there was a case which to the bougie gave the characteristics of the so-called elastic stricture. The endoscope showed a white bridge of tissue extending directly across the urethra from side to side, behind which a sharply curved probe was passed, the point

of which coming in view, isolated in the curve of the probe, the bridge of tissue, and traction being made on the probe, clearly proved the diagnosis.

The endoscope is merely an urethral speculum, through which, with the reflected light of the mirror, one can plainly see every part of the urethra; diagnose and treat with exactness the part diseased, just as one does the vagina, nose and throat, and it can be just as easily done. One needs only five endoscopes, 1, eight millimetres long, number 25 French scale; 2 ten millimeters long, numbers 18 and 20, and 2 thirteen millimetres long, numbers 18 and 24. A long slender probe or wire, on the end of which a little absorbent cotton is wrapped to clean the parts, and to apply the medicament. I go into some details because the American authors speak very little of it, because I believe it is not much valued by them.

The surgeons there and in Berlin only know Otis method of treating stricture in theory. The cutting of stricture is rare, very rare indeed. There are surgeons there of large experience who have, perhaps, never made an internal urethrotomy. The method is universally by gradual dilation, and the large numbers are not used. Number 28, French scale, being considered large. Billroth and his assistant, Eisilberg, perform many bold operations. In going through the wards, I saw a case upon May 23d, in which there had been a resection of almost the entire 2d, 3d, 4th, 5th, 6th, 7th and 8th rib, and the patient is doing well with an immense hole in his chest into which the fist could be thrust, and the respiratory movements of the lung are plainly visible. It was done for chronic empyema (upon which a partial resection of two ribs had been previously made without benefit) that the chest walls might retract, and the pleural surfaces approximate and the cavity be obliterated.

A case also of cancer of the rectum in which he had removed the entire rectum, almost the entire sacrum and all of the posterior vaginal wall, (the anterior vaginal wall and mouth of the womb were plainly visible, when the dressing was removed) and the patient was well after this extensive mutilation.

In the pathological room, Prof. Kalisko exhibited the internal viscera of a patient that had died from the "dropsy," dependant on cardiac disease. The mucous membrane of the intestines was intensely congested, and had numerous ulcerations quite through to the sub-mucous tissue. These ulcerations were due, he explained, to the administration of calomel, which, passing into the circulation, came in contact with the sulphur of the intestinal canal forming an escharotic mercuric salts. These ulcerations he had often noticed in cases of general œdema in which calomel had been given, but he said that they were of no importance, as they soon healed.

In the medical wards, I learned that all cases of "dropsy" not dependant on disease of the kidneys, were treated with 8 to 12 decigrams of calomel each day until there was a slight tenderness of the gums; this allowed to pass away, when calomel again was given and so on in repetition. It is not given where the kidneys are diseased, because they then fail to respond to its influence, because it is an irritant diuretic that aggravates the disease.

This classification of calomel among the diuretics and its use as such in the general œdemas, originated in Europe, and has been used some in New York. The writer has never tested the treatment because he has not thought it correct in theory as to the action of the remedy, or being so, would not be warranted by clinical results.

When he has given calomel in such cases, it has been upon the principles which would indicate it in any disease where there was a sluggish action of the entire elimnatory functions with a view chiefly to its action upon the liver and alimentary canal.

In such cases where the urine, previously red and scant, has become clear and free following its action, he has regarded it as a result of the free cleansing of the system, as it were, through the alimentary canal, as a result of which all of the organs resumed, to a more or less degree, their normal functions, in which the kidneys also participated secondarily, and which any good purgative would produce. But accepting the observation of these eminent men as to the direct and potent diuretic action of calomel, the treatment is yet not the

best that can be given, as there are other remedies which are equally as good, and which produce little general depression, and no local lesion.

The treatment of dropsies due to organic causes, can only be symptomatic and palliative, the object being, by attention to diet and drink, to give the greatest amount of nutrition with the minimum of fluids, and to remove the œdema by those means which will the least depress the system or disturb the digestion.

Calomel is a remedy depressing in its effects when given in large and repeated doses, and to salivate a patient even in an acute inflammatory disease is not desired and is especially bad in one whose course is chronic and incurable. In such cases Glauber's salts, in doses from one to two tablespoonsful two or three times a week, (given before breakfast) has seemed to the writer, to be of great value. There are usually four or five large watery actions with no depressing effect, and slight disturbance of the digestion, which sometimes gives such relief from the dyspnœa that the patient will request another dose.

Since, therefore, calomel produces ulcerations in the intestinal mucous membranes sometimes, it must surely at all times produce great irritation of it, and therefore is not a good remedy when so administered.

I have said nothing in other letters written you of Koch's lymph, because every one is so familiar with its history. It is yet used by some there for diagnostic purposes, or rather as one of the means of verification, and also sometimes as a therapeutic measure in the external forms of tuberculosis, in which however it has no advantage over other means of treatment or is not so good. In lupus, the old method of thoroughly curetting is more certain of prompt relief and it is just as permanent.

Koch, in a very recent publication, claims to have eliminated the fever producing element. This is much accomplished.

While speaking of lupus and tuberculosis, it may be perhaps interesting to know that Kaposi, the great authority on skin diseases, stands boldly alone in his adherence to the old

idea of classifying these diseases as distinct pathologically. Since the discovery of the bacillus of tuberculosis in both diseases, and since the behavior of Koch's lymph is similar in both, pathologists have regarded them as one and the same process.

These observations Kaposi regards only as incidents in the action of a remedy, and the discoveries of the microscope, and believes the bacillus, not the "*proctor hoc*" of lupus. His reasons are based on the widely different clinical histories of the diseases.

Lupus is a disease of the skin and remains local, is long in its duration, sometimes existing for over thirty years, is never fatal, and in the track of its ulceration there is often new and permanent tissue formed. Whereas, typical tuberculosis may and does attack every tissue of the body, is never local, is short in duration, always fatal, and its ulcers never heal permanently in one of its parts while still progressing in another.

Clinical observations sometimes should have as much weight in classification of diseases, pathologically and etiologically, as the microscope or a remedy. And that when in given diseases, the clinical histories of which are widely diverse, the microscope which only finds one and sometimes two minor and perhaps accidental points of analogy, should make a classification, is not in harmony with the usual law of the greater weight of evidence, establishing a decision. There are tumors which pursue widely different clinical courses, which the microscope cannot foretell positively. The time will doubtless come when it can say that such or such a new formatian or cell is malignant and will recur and produce death, or is harmless in character, but until it does, we let clinical history classify them.

The eye men there are Stellwag and Fuchs, both of whom always make an iridectomy in cataract operations.

Politzer trepans the mastoid cells often for suppurative conditions with the small chisel and mallet, scraping out the diseased cavity with the sharp spoon, as also in Berlin.

There are many Americans in Vienna, and they all, who are studying throat and eye diseases, find in Dr. Frank Sims,

(who once lived in Atlanta, and is a brother-in-law of the late Dr. Bizzell) a most valuable friend. He is an assistant in Prof. Schnitzler's throat, and Prof. Fuchs' eye clinic. The life in Vienna seems to agree with him.

I hope the hasty putting together, and the cursory mention of merely the leading points of some of the notes I have taken during my nearly eight months stay in Europe, as embodied in these notes and the letters I wrote you before, may have been of some interest to your readers.

THOMAS M. MCINTOSH.

AN INTERESTING CASE.

Mr. J. V., a young man twenty-one years of age, was first seen July 5, 1891. Had been for eight months under treatment of syphilis, and all the while growing worse. Was very much prostrated, and was suffering with an immense abscess on the outer portion of the upper third of the left thigh; also one on the left side of the neck. Had, moreover, a large tumor on the right side of the neck and a still larger one on the back, both tending, of course, to suppuration. Prescribed verrhus clemiana, two teaspoonfuls four times a day, to be increased in two weeks to four teaspoonfuls.

At the expiration of two weeks, the abscess on thigh was discharging profusely, general appearance of patient improved, and he reported himself as feeling much better. Ordered the dose increased gradually to six teaspoonfuls, four times daily.

At the expiration of six weeks the abscess on thigh was still discharging freely; the one on neck scarcely at all. Ordered the suspension of the medicine for a week, during which time the discharge from abscess on thigh diminished perceptibly; the one on the neck ceased entirely. On resuming the medicine, the discharges from both abscesses became again profuse, and so continued for about two weeks longer, when it began to subside; the tumors began to diminish in size, and in four months from the time the treatment was commenced, all symptoms of the disease had disappeared. Advised him however, to continue the medicine a few months longer.

J. EMMETT BLACKSHEAR, M. D.

Society Notes.

CLINICAL SOCIETY OF MARYLAND.

BALTIMORE, March 4, 1892.

The 263rd regular meeting was called to order by the President, Dr. Robert W. Johnson.

DR. HERBERT HARLAN spoke of a case of buphthalmus which had recently come under his care. Buphthalmus is simply a very large eye. It is very rare; in over 26,000 cases at the Presbyterian Eye and Ear Hospital, not one case of buphthalmus has been recorded. There are some cases put down as bulging of the cornea and probably one or two of them were cases of congenital buphthalmus. Dr. Harlan's case is a girl of 11 years; both eyes effected, but one larger than the other. The condition was noticed at birth; eyes gradually grew worse. Sight was never good In one eye the cornea became completely opaque and there was a good deal of inflammation and pain for six months, and then all light perception was lost. The other eye has likewise been somewhat painful; it is enormously enlarged, almost as big as the eye of an ox. Cornea of about usual thickness; tension about normal; iris a little thin and apparently a little stretched about margin. Eye exceedingly myopic. It looked like any other eye except its enormous size. Quite a number of cases of enlarged eyes are reported, but they are not perfect like this one. Dr. Harlan saw another similar case recently in a negro man, but the eye was defective. It was 1 1-2–1 3-4 inches in diameter. The eye was removed. Vitreous and lens opaque, cornea cloudy and ciliary region inflamed.

DR. ROBERT RANDOLPH: I found about a year ago, in a bottle at the Eye and Ear Hospital, a bulpthalmic eye. It was evidently taken from a child 6 or 8 years ago. There was a marked cylinder-shaped excavation of the optic nerve very much as we see in glaucoma. The eye was thin; it was full of holes showing that it was much atrophied. The ciliary body was atrophied; cornea cloudy.

I think Nettleship reports a case in which iridectomy has done good. I understand that there is a case in France where the vitreous is systematically drained.

DR. CHAMBERS: Was the rest of the face symmetrical in Dr. Harlan's case?

DR. HARLAN: She is a very pretty little girl.

DR. RANDOLPH: Is it not generally one-sided?

DR. HARLAN: It was double in both cases of mine, but one eye larger than the other. In these two cases, I looked at the optic nerve and there was no depression. I think it likely that the one Dr. Randolph found was one of secondary glaucoma.

DR. RANDOLPH: It was one of hydro-opthalmus in a child.

DR. J. L. INGLE reported a case of osteomyelitis, in which the symptoms during life were so misleading that the real nature of the disease was only discovered at the autopsy. A healthy boy of 14 was for several days less vivacious than usual, then on Nov. 20th, '91, was taken seriously sick. Previous to the 20th, there had been a festered spot on left ankle which had apparently healed. On 20th, fever 104 deg., severe pain in left leg from knee to toes. Fever high till 22d, when it fell to normal. On this day had some epistaxis and on following day tympanites marked. Acute rheumatism was diagnosed, and salicylate of soda given. Mind wandered from the first, constant headache from beginning to end with persistent insomnia. On the 23d, Dr. Earle suspected typhoid fever from delirium and epistaxis. Dr. Ingle was inclined to regard it as a case of cerebral meningitis; the child lay with both eyes closed, was irritable when aroused, avoided light, was constipated, surface pallid, erythematous blushing, dilated pupils. Instead of a retracted abdomen there was an enormously distended one. At this time there was marked soreness all over the body. Patient put upon iodine and bromide of soda, but no benefit derived. Tympanitis increased and interfered with respiration and circulation.

The child died, and an autopsy was made by Dr. Chambers.

DR. J. W. CHAMBERS: The meninges of brain were markedly congested and there was just such a condition as one would expect as the result of sepsis. There had been, seem-

ingly, no definite cause for sepis. The sore on the leg had scabbed over and was dry. Looking over the extremity it was observed that his left leg over the tibia was enlarged and œdematous, and this caused us to cut down. The periosteum was œdematous and red and easily detached. When ripped away quite a large amount of bloody pus oozed from the center of the tibia. No other bones were allowed to be examined, although from the fact that he had had pain in the other leg and elsewhere in the body, we suspected that it was a case of multiple osteomyelitis involving several bones.

As an idiopathic disease, osteomyelitis has not received much attention until within the past few years. The cause of the disease is probably simply the pus microbe getting into this particular locality. It is probably always secondary to some pus formation elsewhere in the body. Some think it is absorbed from the alimentary tract, the bronchial mucous membrane or other sources and then finds its way into the the bones—mostly young bones near the epiphyses. The disease is often difficult to diagnose. Holmes has said that average number of these cases are diagnosed on the autopsy table. We have few definite symptoms to guide us. I do not think any doctor should feel chagrined if he should fail to diagnose osteomyelitis in such a case as the present one. It is probable that many cases die under our care that we have diagnosed as something else. I have seen but three cases, two I recognized at once, the third only after the death of the child. The only distinctive symptom, was intense pain at one point. By pressing over the bone, if the individual is not thoroughly affected by the septic condition, you can find tenderness. The prognosis is bad; multiple cases are very little modified by medical or surgical treatment. Where only one bone is involved, if we recognize it or suspect it, I should not hesitate to trephine. We can in this way save a number of lives or a good deal of destruction of tissue. I would not have any more hesitation in boring into a pus cavity in bone than in opening an abscess in the soft tissue. In multiple cases the sepsis is so great that there is scarcely anything to be done either by surgeon or physician. Under these circumstances I would not hesitate to give relief to tensions.

DR. W. S. THAYER: I saw, some 3 years ago, at the Massachusetts General Hospital, a case very similar to the one reported, except that the bone was the femur. A boy of 14 was admitted to the medical side with a diagnosis of sciatica. He had been treated by a reputable physician for ten days with this diagnosis. For a week before entrance, had had occasional chilly sensations, but no actual chill. He was in a typhoid condition, dry, brown tongue and high fever. I found upon examination that the upper part of the thigh on one side was distinctly larger than that on the other side, somewhat tense to feel and rather hot. He was immediately transferred to the surgical side, an opening was made and a large quantity of pus was found. The boy was in a state of septicæmia from which he did not recover.

DR. S. T. EARLE reviewed the literature of osteomyelitis with especial reference to causation.

DR. J. M. T. FINNEY: This disease in a certain number of cases is difficult to diagnose; in certain other cases it is not. I happen to have seen two or three of the latter class. As far as the pathology is concerned, I think it is simply a bone abscess. The treatment is like the treatment of a like condition in other tissues, viz., where there is pus evacuate it.

The resemblance of this disease to appendicitis is very marked. It gets well in many cases and will return again. As we are coming more and more to operate in appendicitis, so we ought more and more to operate in myelitis.

There is one point in diagnosis which Dr. Chambers has not referred to and which seems to me a most important one, viz., local œdema.

Local œdema seems to me to be the most characteristic sign of pus deeply seated.

Dr. Finney related 3 cases operated upon by himself, all making good recovery. The staphylococcus pyogenes aureus was found present in all these cases.

DR. CHAMBERS: As to œdema, a good many cases may die from sepsis before œdema is present. If you get pain and œdema then the diagnosis is more sure.

DR. S. T. EARLE: I saw the case reported in the early stage. There was no point of localized tenderness. He was tender

from the knee down, with no point worse than another. In about two days after the onset there was just as much tenderness over the right limb as over the left, and this hyperæsthetic condition soon became general. As to œdema, the limb was only a trifle larger in the whole extent from the knee.

DR. J. M. T. FINNEY then read an exhaustive paper on "Appendicitis."

DR. W. S. THAYER: A number of men in Munich have collected 1000 cases of appendicitis in the Munich hospitals. A German doctor has analyzed these cases, and arrives at the conclusion that appendicitis is fully as common in females as in males, if, indeed, it is not more common. As to age, he finds the proportion almost exactly the same in old age as in youth.

Operation must be governed by surroundings. In a large city where we have good surgical skill, I believe that where the symptoms progress 24 hours the case should be handed over to the surgeon. I believe the majority of these cases belong to the surgeon.

DR. J. D. BLAKE: There is no doubt but that under proper conditions an early operation is advisable. To induce the patient's family to permit the operation to be done at his home or at a hospital is often impossible.

I was rather struck with Dr. Finney's idea of combining all these conditions—typhlitis, perityphlitis and appendicitis—because it is a difficult thing to know just which you have.

I remember that Dr. Chew once said that at a meeting of the American Medical Association the physicians were discussing appendicitis on the medical side, and concluded that at a very early day such cases should be handed over to the surgeon for operation. At the same time the surgical section were discussing the same thing, and concluded that an operation should not be performed too early; that it was better to wait.

I have seen two cases where an early operation showed that the trouble was located in the appendix, which was removed. In two other cases that I have seen there was so much adhesion that it was difficult to determine where the trouble was.

I remember one case, in a young man, where the aspirator was used to determine the presence of pus. Three and one-half ounces of pus were drawn. It was thought better not to withdraw it all, as the walls of the abscess might collapse, and there would be a tear into the abdominal cavity. The patient has since had no further trouble. Eight months ago I was called to a young man with appendicitis. I advised operation, which was declined. Five days later I aspirated him, and drew away nearly four ounces of pus. The next day I drew away a little over two ounces of pus. This patient has never had any trouble since. I had a similar case six months ago, in which I aspirated twice. He has since complained of pus about that region, and I have recommended an operation. Certainly where the diagnosis is not plain, an aspirator rarely jeopardizes the case, and very often throws some light upon the trouble. In another case in which I used an aspirator I got about three ounces of blood, and the symptoms all disappeared.

DR. J. F. MARTINET: I am distinctly a medical man, but I have been converted through personal experience to the belief that appendicitis is distinctly a surgical trouble. The cases which I have attended have come on abruptly with acute pain. I have had four cases in my practice within twelve months. Two of the cases Dr. Chambers saw with me. An operation was advised, but in neither of the cases would the family consent. My habit at present in every case I meet with is to state that it is a distinctly surgical trouble and refer it to the surgeon. One of my cases who refused operation secured relief by suppuration through the bowels. This was a year ago. In July last she passed through another attack safely. Lately she was operated upon by Prof. Kelly and is now well.

DR. J. W. CHAMBERS: The statistics from the medical side seem to be faulty. A person may have three or four attacks, and they are reported as four cases cured. A surgeon operates upon a case and reports one case.

As to women having it as frequently as men, I have under my own observation known of three women upon whom the gynæcologists had diagnosed pelvic cellulitis and salpingitis,

and removed the "tube" which proved to be the appendix. In a large number of cases the appendix is really a pelvic organ, and if inflamed it will certainly be a case of salpingitis with some gynæcologists. Such errors may have something to do with statistics. There is no reason in the world why women should escape more than men; certainly they are just as liable to catarrhal affections.

Referring to aspiration, I think Dr. Blake's patients are relieved rather than cured. I should hesitate to use the needle. If I should find pus with the aspirator, I should never feel that I had done my duty unless I had cut down and removed all the pus. It would not be good treatment for an abscess in the iliac region.

DR. INGLE: I believe the sooner we place these cases in the hands of the surgeon, the better. When the family would not consent to an operation I have treated these cases with salines and enamata without any relief whatever.

DR. THAYER: In the Munich statistics, it is said that undoubtedly cases of appendicitis had been called salpingitis and pelvic cellulitis, and many cases in the female were doubtless missed in this way.

DR. MARTINET: Two of my cases occurred in females, one of 5 years, the other of 10 years of age.

DR. BLAKE: There are certain cases where I can find no distinct indication of what my patient has, whether it is typhlitis, perityphlitis or appendicitis, and when I have waited long enough, I put in an aspirator to find out if there is pus and in no case have I seen bad symptoms follow, and in some there was distinct benefit. I think we are thoroughly justified in using an aspirator to make a diagnosis.

DR. FINNEY: As these are pus cases, the operation can be done as well at the patient's home as in a hospital.

As to aspiration, I agree entirely with Dr. Chambers. Where there are sufficient indications for aspiration, there are still more indications for the use of the knife.

DR. W. T. WATSON, Sec'y.

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Book Reviews.

THE MEDITERREANIAN SHORES OF AMERICA, SOUTHERN CALIFORNIA, ETC.—Climatic, physical and meteorological conditions, by P. C. Remondeno, M. D., San Diego, Cal.

The introductory chapter is taken up in discussing climatology, the relation it bears to the etiology of tuberculosis. The following texts are successfully disposed of in an interesting style, viz.: Meteorological conditions and disease; sea air and marine climate; ocean moisture and soil moisture; rain and rainy weather on coasts; misapplied terms as to moist climate; extreme dryness of the air; consumption and temperature; geographical limits of consumption; the relative merit of altitude; why phthisis is more prevalent on lower elevations; are altitudes exempt from consumption? equability of temperature an important factor; different effects of sunshine and shade.

To sum up the writer's views briefly, he concludes that Southern California is all that can be desired as a home for the phthisical and invalids from other causes, that require an equitable and aseptic atmosphere. These conclusions are based upon observations and experience in this section of California covering a series of years devoted to the study and treatment of disease. The writer thinks that the tubercle bacilli will ultimately disappear in an atmosphere so unfavorable for its growth and well being. Glowing description is given of the beautiful and picturesque landscape and the salubrious and enchanting climate. The illustrations render the book attractive. The volume would form a valuable addition to the physician's library. It is published by the F. A. Davis Company, and is in keeping with the neatness and taste so characteristic of the company. A. B. P.

BACTERIOLOGICAL DIAGNOSIS.—Tabular aid for use in practical work. By James Eisenberg, Ph. D., M. D., Vienna. Translated by Norval H. Pierce, M. D. Published by the F. A. Davis Co.

This tabulated monogram is a valuable addition to the aids of bacteriological research to the practical worker. It is time saving in keeping before him the differential points in summing up a diagnosis of a species of micro-organisms. Koch's methods of analysing or dissecting (so to speak) bacteria are adhered to. The appreciation of bacteriologists of this book is shown in the fact that the first and second editions appeared within a year.

The appendix gives the technique used in the cultivation and staining of bacteria. A. B. P.

EYE TROUBLES IN PREGNANCY.

As the conclusion from a very interesting paper on the "Induction of Premature Labor, in Amaurosis and Amblyopia in Pregnancy" (*Jour. Am. Med. Asso.*), Dr. Pooley says:

1. In all cases of pregnancy, not only should examinations of the urine be systematically made, but the eyes should be examined with the ophthalmoscope; since, in a large proportion of cases where eye troubles exist, the patients make no complaint of disorders of vision. Frequently such troubles can be detected with the opthalmoscope long before any disease of the kidney is shown in the urine.

2. In uremic amaurosis, without changes in the eye visible to the ophthalmoscope, even should the usual accompanying symptoms, such as dizziness, nausea and threatened convulsions be absent, their supervention is soon to be anticipated, and the immediate induction of premature labor is indicated, without waiting until the life, as well as the sight of the patient is in danger.

3. In neuro-retinitis, the induction of premature labor is not only justifiable, but urgently demanded. In some instances it is called for even in the earlier months of pregnancy.

4. It is required in cases of eye trouble recurring in successive pregnancies.

5. A woman having suffered in this way during pregnancy, the relationship of cause and effect should be fully explained, both to herself and her husband.—*Med. Brief.*

Selections and Abstracts.

BROMIDE OF STRONTIUM IN EPILEPSY.

Interesting tests of this salt in epilepsy were made by Dr. Ch. Fere who reported his results to the Paris Biological Society on October 21st, 1891. M. Fere first administered the medicament to a series of epileptics who had long been treated by the bromide of potassium and whose condition had been ameliorated by the use of the latter salt. But he had found that after the potassium bromide treatment, and in spite of the fact that there had been an amelioration in a general way, the patients were subject to serious relapses and that grave, nervous crises supervened. He found that after using the bromide of strontium, these relapses and crises did not appear, and he clearly states his conviction that this salt should supplant the bromide of potassium in the treatment of epilepsy. Concerning the physiological effects of the two salts, Dr. Fere remarked that he found that the strontium bromide exerted about five times less toxic power than that of the potassium salt. This observer also developed the important fact that a given quantity of the bromide of strontium produced the same therapeutic effect as the same amount of bromide of potassium. This is the more remarkable as the former contains about one third less bromine than the latter, or, in other words, 1 1-2 grains of the strontium salt contains the same amount of bromine as 1 grain of bromide of potassium. Of course, other things being equal, the advantage would lie with the medicament which would give the better results with the smaller quantity of the metalloid. Like other observers, M. Fere insists upon the purity of the medicament, which he considers to be an absolute *sine qua non* for therapeutic efficiency, and, for his own tests, he made exclusive use of the bromide of strontium (Paraf-Javal.)

BORAX IN EPILEPSY.—Dr. Maiset has obtained excellent results in the treatment of epilepsy by borate of soda. He finds it more efficacious than the bromides in symptomatic epilepsy, but less so in the nervous forms.—*Le Progres Medical.*

A NEGLECTED METHOD.

At a recent meeting of the New York Surgical Society, Dr. Charles McBurney read a paper entitled "A Neglected Method of Modifying General Anæsthesia." The method consists in placing a broad, elastic tourniquet around each of the thighs as well as around the upper limbs before the etherization is commenced, thus shutting off from the general circulation a considerable portion of the blood. He has employed this method about ten times at the Roosevelt Hospital, with very good results. The patient is usually brought under the influence of the ether in a very short time—in most of the cases, within three or four minutes. The trembling of the limbs, so annoying to the operator, especially in operations about the perineum, is entirely absent. The patients usually recover from the effects of the anæsthetic within two or three minutes after the tourniquets are loosened, and in no case has vomiting occurred. Some precautions are necessary. In case a hypodermic is given before the ligatures have been removed, the quantity of the drug must be considerably smaller than the usual dose. The ligatures are first applied loosely so as to retard only the venous blood; then when the limbs are surcharged, the bandages are tightened so as to completely stop the arterial circulation as well. Dr. McBurney then brought a man before the society and gave a practical illustration of the method. He stated that until a short time ago he thought the method a new one; since then, however, he has found it advocated in a letter to the New York Medical Journal, published in 1887, by Dr. Leonard Corning, of New York, as well as by others. He had, therefore, changed the title of his paper and called it "A Neglected Method" instead of a New Method.—*Medical Age.*

REUNION OF CUT-OFF FINGERS.—Gluck ("Deut. med. Woch.") reports the case of a butcher who cut off with a cleaver the terminal phalanges of the left ring and middle fingers. The resultant wound was disinfected and the parts sutured. Perfect union resulted. Similar cases are reported in the *Medical Standard*, Vol. I to X.—(*Ex.*)

AMENORRHŒA ON SCHOOL GIRLS.—Dr. T. A. Reamy, (*Cincinnati Lancet-Clinic*), in discussing the amenorrhœa in anæmia, common to school girls, says: (1) She must leave school, and must not even study at home. (2) She must spend several hours each day in the open air, either walking or riding. In winter she must, of course, be warmly clad, but must wear no sheep-skins or other chest-protecting pads. Standing in the open air, she must be induced to breathe deeply with the mouth closed; this should be done for at least fifteen or twenty minutes, and be repeated at least twice a day. Nothing that can be done will more rapidly improve the character of her blood. (3) She must sponge her extremities and body each morning on arising from bed. The water must be of the temperature of the room, and she must practice freely with an ordinary towel. (4) She must drink plenty of milk and eat plenty of beefsteak. (5) She must take small doses of iron, combined with some bitter tonic, three times a day. Improvement may be somewhat slow, but if this course is faithfully carried out, a perfect cure will result, and her education may then be finished. If this course or its equivalent be not followed, the cases will go from bad to worse, and finally die from pulmonary tuberculosis.—*Southern Practitioner.*

PENETRATING ABDOMINAL WOUNDS.—In our "Selections" will be found a very excellent article from *The Epitome* by Dr. W. B. Coley. Mention is made of it here to emphasize the importance of an early operation, if at all. So soon as the primary shock can be overcome, the case should be well considered in all its details, and if an operation is decided on, perform it at once, or not at all. Several operations have been made in this city during the past few years with a certainty of the failure that followed. The idea of waiting twenty-four to forty-eight hours, or in some instances, even longer, as has been done, may assist in perfecting the manual dexterity of the surgeon, but as for giving a chance to the patient, it only insures the chances for his early need of an undertaker.—*Southern Practitioner.*

INTERNATIONAL PERIODICAL CONGRESS OF GYNÆCOLOGY AND OBSTETRICS.

FIRST SESSION.—Brussels, Belgium, Sept. 14 to 19, 1892.

The following named distinguished gentlemen have been delegated to represent the British Gynæcological Society at the International Congress of Gynæcology and Obstetrics, next September: Robert Barnes, Granville Bantock, A. S. Simpson, Lawson Tait.

Great preparations are being made to entertain visiting physicians. His Majesty, King Leopold, will assist at the opening of the congress. There will be a grand reception by the Belgian Gynæcological Society; gala performance at the Grand Opera; also a banquet by the British Gyn. Society; garden party in the garden of the royal family, etc.

For all information relating to the congress, address,

Dr. F. HENROTIN,
353 LaSalle Ave., Chicago, Ill.

CHLORIDE OF IRON IN TYPHOID FEVER.—Dr. J. W. Anderson describes in the *British Medical Journal* a mode of treatment for typhoid fever which he has found very effectual. It consists in administering a full dose of the liq. ferri perchloridi fort., namely, 5 minims (for an adult) every hour of the day and night, until a week has elapsed from the complete subsidence of the fever. To enable the patient to take this, the dose is combined with half a drachm of glycerine or 1 drachm of simple syrup, and a few drops of tinct. zingib. fort., and diluted in half a tumblerful of water. If sickness is caused, 5 grains of bismuthi subnit. are given ten minutes before each dose of the medicine until nausea ceases to be produced. In a few days the diarrhœa will be arrested, and thereafter a mild aperient must be given daily as long as the medicine is continued. In a moderately severe case, not brought under this treatment until the end of the first week of fever, it will take, the writer says, ten days to reduce the temperature to normal. If the medicine is not given every hour night and day it will take a little longer; if begun within two or three days of onset of fever, the latter will be gone in about five days.—*Medical Record.*

ACUTE RHEUMATISM.

℞ Euonymin, gr. 1-4.
Podophyllin, gr. 1-8.
Aloin, gr. 1-8.

M. Ft. pil. No. 1. Sig.—Give night and morning as necessary.

Give alkalies till saliva is alkaline. Following is a useful combination:

℞ Lithii benzoatis, dr. ss.
Sod. brom., } aa dr. ij.
Potas. carb., }
Potas. acet., oz. jss.
Sodii phos., oz. ss.
Syr. zingib., } aa ad oz. vj.
Aq. menth. pip., }

M. Sig.—Dr. ij to oz. ss in water, four to six hours after meals.

For antipyretics use antipyrin gr. x and digitalis gr. j, combined. For analgesics use phenacetin or antipyrin, and, if necessary, a combination of morphine, bromide, and chloral. Give alkaline mineral waters copiously. Give tonics, the following being excellent:

℞ Tr. ferri chlor., dr. iv.
Tr. nuc. vom., } aa dr. ij.
Ac. phos. dil., }
Syr. aurantii cort., oz. j.
Elix. calisaya, q. s. oz. ij.

M. Sig.—Oz. j in water t. i. d. before meals.

If heart weakens, use following:

℞ Spts. ammon. aromat., oz. iij.
Ammon. carb., dr. j.
Tr. cardomom. oz. j.
Tr. nuc. vom., dr. iij.

M. Sig.—dr. j t. i. d.

For topical application use:

℞ Tr. aconit. rad., } aa oz. ss.
Tr. arnica, }
Chloroform, oz. j.
Tr. saponis camph., oz. ij.

M. Sig.—Apply locally.

Exclude nitrogenous foods. Salicylates, baths, and massage are of doubtful value.—F. Le Roy Satterlee, M. D.—*Med. Age, April 25, 1892, p. 255.*

A NEW YORK MALPRACTICE CASE.

A malpractice suit has just been tried against a physician of Fishkill Landing, New York, with the result of awarding a verdict of $2,500 damages against him. Some time since, a drayman fell from his cart and broke his arm. The bone protruded from the flesh, and the wound was filled with dirt. It was dressed and looked after by the physician, but the patient found it necessary to enter St. Luke's Hospital, New York, after about a month, at which time the arm was swollen to double its usual size. When he left the hospital, the arm was useless and will always remain so. Suit was therefore brought for malpractice, the claim being made that the wound was not properly cleansed. The damages were laid at $5,000 and a verdict given for $2,500.—*Buffalo Medical and Surgical Journal.*

TREATMENT OF HEMORRHOIDS.—Dr. J. Brindley James writes to the *British Medical Journal* of February, 20, 1892, that he has for some years been in the habit of treating hemorrhoids by the simple process of applying calomel to them with the finger alone, and without a single exception he has done so with marked success, especially when inflammatory action was obvious in the hemorrhoidal mass, characterized by mucous discharge and hemorrhage, accompanied by most painful sensation of weight in the rectal region. All these symptoms under this simple influence were speedily relieved, with the still more important subsequent advantage of the patient's restoration to ease. "Only a few days ago," he writes, "a patient came to me suffering so acutely that he could neither sit nor walk freely, each movement of the body entailing exquisite pain. I have now seen him thoroughly enabled to pursue his usual occupation in happy immunity from these distressing symptoms."—*Medical Record.*

PREGNANCY AFTER DOUBLE OOPHORECTOMY.—Dr. J. A Robertson ("Annals of Gyn. and Pæd.") has performed double oopho. rectomy for cystic ovarian disease in a 23-year-old girl. Three months thereafter she menstruated. Five months after she married, became pregnant and was delivered of a healthy boy.—(*Ex.*)

Editorial.

A GROWING EVIL WHICH SHOULD BE REMEDIED.

There is an evil that physicians meet with almost daily—the renewal of a prescription by patients or some one they may have given it to, without proper directions from the prescriber.

This is a growing evil that may do incalculable harm to the physician and the person taking the contents of the prescription alike. By the patient renewing the prescription and not returning for observation as to the effects of the remedy, which may need changing, etc., and the patient not deriving the beneficial results he expects, charges it to the physician; also by having his prescriptions hacked around, to be used in some self-made diagnosis either in the patient or his friends. For we meet people every day who have a number of prescriptions in their pockets they have collected from time to time, to be used on such occasions as they think proper, by themselves and friends.

* * *

How frequently we are met by the statement from patients that they have been taking Doctor Smith or Jones' medicine a long time, without any good results, and upon inquiry you find they have never seen the physician but once; that he gave them the prescription and told them to come back in a few days, but they did not think it was necessary to return as they were taking the medicine. Or you ask a patient who has been quite sick, why a physician was not called in earlier. "Well, doctor, our cook had some medicine a doctor gave her when she was suffering nearly the same way. It cured her in a few days, so I thought I would try it." Take any long continued disease, syphilis for instance, your patient will come regularly during the active stage, but as soon as the symptoms are in obeyance, his attendance will either cease or become irregular, though he may have his prescription filled

and take it spasmodically, but when his symptoms return he never forgets to blame his physician for the bad results.

* * *

The remedy that suggests itself to our minds for the correction of this evil, is to have printed on all prescription blanks, *This prescription not to be refilled or a copy given.* At first blush this may seem arbitrary and uncalled for, and apparently means additional trouble and inconvenience for both physician and patient, but its advantages are many, as can be seen. It insures the physician seeing his patient, his condition, whether the remedies are having the desired effect or necessary changes should be made, and whether the directions as to dose, regularity of taking, etc., are carried out properly. These few words added to the prescription blanks means, more fees for the physician and quicker cure for the patient; you can keep your patient in regular attendance and under proper observation, for we can regulate the quantity for any desired length of time, and the patient necessarily returns to you before he c- have it refilled. If they do not return, we have the satisfaction of knowing that they are not getting the benefit of one experience without paying for it, nor will it be possible for them to "hack" the prescription around promiscuously.

* * *

There is one class of prescriptions that by all means should have this on them—any prescription that contains morphine, chloral, whiskey or any drug that your patient is apt to fall into the habitual use of. A physician told me an incident that occurred in his practice, that fully illustrates how a patient may hold on to and take a prescription of this kind. "One day a man I did not recognize, but who was redolent with the fumes of whiskey, came up and spoke to me, Why, doctor, you don't recognize me?' 'No, I do not,' I replied. 'Well do you remember this?' he said, reaching into his pocket and pulling out a well worn piece of paper, which he handed me. 'It's a prescription you gave me about fifteen years ago and I have been taking it ever since, but I take lots more now than you told me to.' I read the paper, which was a prescription for whiskey I had given him. I

remembered the man, as a patient, who, while convalescent, I had told to get a bottle of whiskey and take three drinks a day until he was well. But he had replied that he was a prohibitionist and a church member—he could not unless I wrote him a prescription. And it was this he had and had continued the use of ever since, still drinking under the subtifuge of this piece of paper. "Well," the doctor said as he finished, "I tore up the prescription and told him he would have to get some one else's authority to continue." W. F. W.

MICRO-ORGANISMS AND THE SWEAT.

Medical science sometimes makes a real advance when it undergoes a revolution. It is only during a very recent period that it has had to modify its knowledge and views concerning the mechanism and role of fever in the economy, and instead of regarding it as a purely pathological process against which we should concentrate our efforts, it is now recognized and conceded to be, within certain limits, a physiological and conservative process, by which the organism protects and restores a lost equilibrium. In the symptom fever we have an index to guide us in the changes incident to leucocytosis and its concomitants of chemotaxis and phagocytosis which are the vital activites of the cell and constitute the veritable *vis medicatrix naturæ*. It is in these important functions of the cells that we find the phenomena by which disease is prevented, arrested and cured, and the degree of perfection to which they are operative and effective is in a large measure directly proportional to the presence of fever. In this instance we have an illustration of a complete revolution in the conceptions and treatment of disease. Again, in the office or function of the skin we have radical views to change for the older ones. Brunner has recently shown from a number of experiments that the microbes of a number of diseases are eliminated by the sweat, and that, indeed, in a number of diseases this is the chief means by which they are thrown off from the organism. After thorough sterilization of the skin of animals, Brunner injected a culture of staphylococcus aureus into a hog, one of anthrax into a cat, and one of micro-

coccus prodigiosus into a sucking pig. In all three cases the microbes injected were found in the sweat and the saliva.

This is one of the most important discoveries, from both practical and theoretical points of view. It gives to crises, accompanied by profuse perspirations which may be produced artificially or naturally, a still more important place than they formerly held. It shows that there is great danger of the patient reabsorbing the secretions. Again in discharging abscesses, erysipelas or other infectious diseases, there is great danger to the patient and his attendants from these sources. It would be a good plan with these facts before us, to subject all linen from a patient suffering from these disorders, after each profuse perspiration, to a change or disinfection in order to lessen the liability to reinfection or new infection from them as sources.

In fear, therefore, the profuse sweat is an attempt of the organisms to rid itself of the morbific agents. It should be encouraged and the products rendered inocuous. J. W. B.

Dr. J. M. Keating, of Colorado Springs, has resigned the editorship of the *Climatologist*.

Dr. William Cobb Whitfield, of La Grange, N. C., has been elected superintendent of the new Orphan Home, established in Goldsboro, by the Odd Fellows of North Carolina.

The American Neurological Association will hold its annual meeting in New York, at the Acadamy of Medicine, on June 22d, 23d and 24th, under the presidency of Dr. C. L. Dana.

EXAMINATION QUESTIONS.—Among the many recent developments of our friends, the belly-rippers, may be mentioned the two following interrogatories to be propounded in future green-room examinations:

"Give the diagnosis of abdominal affections."

"If the patient is a male, he has appendicitis; if a female, pyosalpinx."

"What is the indication for abdominal section?"

"The ability to pay a satisfactory fee."—Ex.

Special Notes.

SANDERS & SONS' EUCALYPTOL EXTRACT (EUCALYPTOL). Whenever mention is made of "Oil of Eucalyptus" we beg you to bear in mind that such reference applies to our preparation, styled for distinction, "Eucalypti Extract (Eucalyptol.)" To avoid disappointment we would suggest to specify, when prescribing, our manufacture. Samples gratis through Dr. Sander, Dillon, Iowa. Meyer Bros. Drug Co., St. Louis, Mo., Sole Agents.

ADVERTISING.—If you wish to advertise anything anywhere at any time write to Geo. P. Rowell & Co., No. 10 Spruce St., New York.

Quinine pills and capsules are very insoluble, being discharged undissolved.

Febriline, or Tasteless Syrup of Quinine, has been found to be just as reliable in all cases as the bitter sulphate of quinine, and physicians will find it to their interest to use it for adults as well as children in place of pills and capsules. It is as pleasant as lemon syrup, and will be retained by the most delicate stomach, having also the advantage of not producing the unpleasant head symptoms of which so many patients complain after taking the quinine sulphate. Possessing these advantages, physicians will find it superior to the quinine sulphate for all cases requiring quinine, particularly typhoid fever.

Among our advertising pages will be found that of the Upjohn Pill and Granule Co., whose pills and granules have obtained such a wide reputation for their efficacy and ready solubility, being so friable as to be easily crushed to a powder under the thumb.

We wish to direct the attention of our readers to the advertisement of the Standard Chemical Co. Their new antipyretic, antizymotic and antiseptic, Quickine, is rapidly coming into daily use and is pronounced an ideal remedy for the physician's use, both for office work and prescribing.

A VEGETABLE ALTERATIVE AND TONIC

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CAUSES THE ELIMINATION OF SPECIFIC BLOOD POISON, the repair of wasted and disorganized tissues, and the restoration of the vital forces to their normal activity. In the treatment of Syphilis it supercedes the use of both Mercury and Iodide of Potassium, and is a reliable remedy for the evil effects produced by the excessive use of these drugs. It is also specially indicated in all Scrofulous Affections, and is invaluable in the treatment of Eczema and other Skin Diseases, in Chronic Rheumatism, Old Chronic Ulcers, etc.

Formula.—Verrhus Clemiana is a Compound Fluid Extract of Clematis Erecta, Prinos Verticillatus, Fraxinus Americana and Rhus Glabrum, with ⅛ of one per cent. of Venanatic Acid, C. H_2 O_2.

Dose—A teaspoonful in water, gradually increased to a tablespoonful, three or four times daily.

ALTHOUGH our Verrhus Clemiana has been before the medical profession for only about two months– too short a time to be fully tested in the chronic diseases for the cure of which it is recommended—we have received quite a number of letters setting forth the flattering results already obtained. We submit the following extract as a sample :

"Tried your Verrhus Clemiana on patient with large ulcer on leg, using Ichthyol externally. Ulcer has healed, and lady quite well. Commenced treatment February 3d, two teaspoonful doses.

"Am using it in a very bad case of syphilis which had resisted everything I could think of. The large copper colored blotches are disappearing, ulcer on leg much better.

"L. W. WHITNEY, M. D.,
"112 West Madison St."

"Chicago, March 7th, 1892.

BEDFORD, PA., March 22nd, 1892.

The Clemiana Chemical Company, Atlanta, Ga.

Gentlemen :—The bottle of Verrhus Clemiana received and used in a case of Chronic Blood Poison. It has produced remarkable results in restoring the vital forces. I would like to have two bottles more.

Will remit on receipt of bill.

Very truly yours,
A. ENFIELD, M. D.

We will be exceedingly obliged to all physicians who will report their experience in the use of this medicine.

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We beg to call the especial attention of our readers to the advertisement of the New York Pharmaceutical Association and their elegant preparation of lactopeptine. It has been found by us to be of especial value in the nausea and vomiting of pregnancy and alleviation of the distressing symptoms attendant upon dyspepsia. We heartily endorse it and ask that it may be given a fair test.

LOUISVILLE, KY., March 18, 1892.

MESS. RENZ & HENRY, Louisville, KY.:

Gentlemen—Replying to your letter of recent date regarding the success which has attended my use of the "Three Chlorides," it gives me pleasure to say that after a thorough and extended test both in private practice and college clinics, I can cheerfully testify to the excellence of the preparation. It would be difficult in a short letter to enumerate all the conditions in which I found it useful. Referring particularly to my gynæcological work I find that your preparation has a special adaptness for many of the cases which I am called upon to treat.

In many pathological states of the pelvic organs its decided alterative action is plainly evidenced in absorbing plastic deposits and in establishing a better nutrition and functional activity.

Very satisfactory results attend its use in anæmia and allied conditions in which amenorrhœa is a symptom. The preparation is very agreeable to take, does not interfere with the digestive functions, consequently may if necessary be steadily and satisfactorily given for many consecutive weeks.

I am glad that you publish the formula openly to the profession, stating not only the ingredients but the amount of each, so that the physician may easily determine its therapeutic indication and use it with precision in each individual case.

Very truly yours,

JOHN EDWIN HAYS, M. D.

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CARBUNCLES AND BOILS.—By *F. A. Alford, M. D.*, Ferndale, Cal.

R. Hydrarg. oxidi rubri, dr. j.
Acidi carbolici, gr. x.
Gum camphor, gr. xx.
Menthol, gr. xv.
Morph. sul. gr. v.
Cocainæ hydrochlor. gr. v.
Lanolin, } aa parts æquales ad
Vaselin, } unciam j. m.

Sig. Triturate carbolic acid, camphor and menthol until liquified; then add the morph. sul. and cocaine, and lastly the mercury. Apply constantly and very freely, with no poultices.

COLD IN THE HEAD.—

A good treatment for this, if the sufferer must be out and about his work is to use a snuff composed as follows:

R. Menthol, 3 gr.
Powd boracic acid, dr. j.
Subnitrate of bismuth, dr. 1 1-2.
Powd. benzion, dr. 1 1-2. M.

Sig. A good-sized pinch of this may be snuffed up five or six times a day; and it will not only relieve the stuffiness and the other disturbing symptoms, but promote a rapid cure.

CATARRHAL AFFECTIONS.—

An excellent cleansing and disinfecting solution for free use in the nasal cavities, by means of the spray apparatus, douche or syringe, is prepared as follows:

R. Acidi boracici, dr. i.
Sodii borat. dr. i.
Sodii chloridi, dr. ss.
Listerine, oz. ii.
Aquæ puræ, oz. vi. M.

CHRONIC GASTRITIS.—

Stearns' Cascara Aromatic, 1 fl. oz.
Tr. Cardamons comp., 1 1-2 fl. dr.
Fl. ext. wood betony, 1 fl. oz.
Simple syrup, q. s. ad, 4 fl. oz.

Mix. Sig. Teaspoonful three times a day before meals.

OTORRHŒA.—

R. Eucalyptol 1-2 dr.
Sodæ bicarbonas, 15 gr.
Sodæ biborat. 15 gr.
Glycerine, 1 dr.
Aquæ ad. q. s., 2 oz.

M. S. Shake, and use as a lotion for the ear.

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CHRONIC RHEUMATISM.—
The following has been recommended:
R. Acidi arsenioci, gr. j.
Pulv. guaiaci, dr. j.
Pulv. capsici, gr. x.
Pil. aloes et assafœt, dr. j.
M. et ft. pil. No. xl. S. One pill three times a day.

FOR HABITUAL CONSTIPATION.—
R. Extract. cascaræ sagrad. fl dr. j
Tinct. nucis vomicæ, m. x.
Tincture belladonnæ, m. v.
Aquæ, oz. j.
M. Ft. haustus. S. To be taken twice a day.—DR. JAMES D. STAPLE, in the *Hospital Gazette*.

FOR THE DRY, RINGING COUGH OF INFLUENZA the following is a good combination:
R. Syrupi picis, oz. jss.
Spts. ammoniæ arom, oz. ss.
Syrupi pruni virg. oz. jss.
Potassii iodidi, dr. ss.
M. S. Teaspoonful 2 to 4 hours apart.—*North Carolina Medical Journal*.

BURNS.—
The following is an excellent dressing for burns:
R. Campho-phenique, oz. j.
Lanolin,
Ung. aquæ rosæ, aa oz. j.
M. Sig. Apply two or three times a day.—*Weekly Medical Review*, Mar. 12th, 1892.

MORNING LAXATIVE.—By *Prof. Henry F. Lyster*, Detroit, Mich.
R. Epsom salts, oz. jss.
Zingiber, pulv. dr. ij. M.
Sig. Two-thirds teaspoonful to wine-glass of water, before breakfast.

DYSPEPTIC VERTIGO.—
Dr. W. K. Harris, of Mulvane, Kan.' uses for dyspeptic vertigo:
R. Acidi nitrici, 60 drops.
Acidi muriatici, 100 drops.
Aquæ camphoræ, 8 oz.
M. Sig. Shake. Take one tablespoonful in one-half cup of water thirty minutes before each meal.

HYPODERMIC ERGOTIN INJECTIONS. —By *Prof. Biedert*.
R. Ergotin, 1.0.
Aq. dest., 5.0.
Acid carbol. 0.01. M.
This solution is totally free from irritating qualities and furthermore keeps for a long time.

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It promptly allays the extreme pulmonary irritations, improves the appetite and overcomes the indifference and distaste for food, increases the weight of the body and begets a sense of comfort not exhibited by any of the noted remedies given in such cases.

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Does not deteriorate with age, as do emulsions of all kinds, but is always fresh and pure, and ready for use.

The dose is small (one or two teaspoonfuls), and therefore it possesses the merit of being inexpensive as well as efficacious, besides is palatable and easy to take, and does not cause eructations or nausea, but is quickly digested by the most delicate stomach.

Here, at the National Capital, it is prescribed by the *entire profession*, with that certainty of result not obtained by any other remedy. By permission we refer to a few of our leading practitioners who use it liberally: Dr Z. T. Sowers, Dr. James T. Young, Dr. J. O. Stanton, Dr. Byrd Harrison, Dr. Ralph Walsh, Dr. J. P. Murphy, Dr. D. C. Patterson, Dr. H. D. Fry, Dr. D. P. Wolhauptu, Dr. Franzonia, Dr. Sprigg, Dr. Harrison Crook, Dr. Bayne, Dr. Hazen, Dr. Brummell, Dr Johnson.

R. Terraline. . . . . oz. xii.

Sig, One or two teaspoonfuls three or four times daily, in sherry wine.

The price of **TERRALINE** is One Dollar a bottle. A full size bottle for trial will be sent, charges prepaid, to any physician east of the Rocky Mountains, on receipt of fifty cents. Literature on the subject will be mailed free.

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VOL. XXII. ATLANTA, GA., JULY, 1892. NO. 7

Original Articles.

APPENDICITIS' TYPHLITIS AND PERITYPHLITIC ABSCESS.*

BY A. H. LEVINGS, M. D., MILWAUKEE, WIS

To the surgeons of France must be awarded the credit of having first called attention to the relationship between abscesses in the right iliac region and diseased conditions of the cæcum or appendix vermiformis.

Dupaytren, in 1820, directed attention to the diseased conditions of the cæcum as a cause of abscess in the right iliac fossa. Loyer and Villermay, in 1824, to perforation of the vermiform appendix as a cause of acute general peritonitis. Shortly afterwards, Puchelt, of Germany, gave to the inflammatory conditions in the right iliac fossa the name perityphlitis, which strictly speaking, means an inflammation of the peritoneum covering the cæcum, but by general consent it has come to represent a localized peritonitis originating either in the cæcum or appendix, and implicating adjacent layers of peritoneum, but confined to the right iliac fossa. Should localized suppuration be established in this inflamed region, a perityphlitic abscess is produced.

Oppolzer, in 1863, brought forward the term perityphlitis,

*Read before the Wisconsin State Medical Society, May 5th, 1892.

indicating an inflammation of the connective tissue behind the cæcum. A faithful history of the anatomy, pathology and treatment of suppurative processes in the right iliac fossa could, however, not be written without making mention of many eminent American and English surgeons and physicians, and among the most prominent should be the name of our own countryman, the late Prof. Willard Parker, who, in 1843, was the first to operate in a surgical sense for a perityphlitic abscess. Hancock, of London, operated in 1848, and advocated the operation in an article in the London Medical Gazette, and he is by many given the credit of having originated the operation. It was, however, generally discredited until Willard Parker, in 1867, reported four cases treated by incision, of which number three recovered. Probably no one man has done more to place these inflammatory processes in their true anatomical and pathological light than Frederick Treves, in his Hunterian lectures on the "Anatomy of the Intestinal Canal and Peritoneum in Man," as well also as in his subsequent writings.

ANATOMY OF THE CÆCUM AND APPENDIX REFLECTION OF THE PERITONEUM.

The cæcum, when in its normal position, is in the right iliac region, and is that portion of the large intestine placed below the entrance of the ilium at the ilio-cæcal valve. It rests upon and its tip just projects over the internal border of the psoas muscle. Its lower extremity will just reach a line drawn from the middle of Poupart's ligament to the umbilicus at the junction of its middle and lower thirds.

The cæcum, is as a rule, about three inches in breadth and two and one-fourth inches in length. The ilium enters it at right angles from the left.

Text books on anatomy have taught that the peritoneum was reflected over the anterior portion of the cæcum, leaving its posterior portion uncovered, but connected to the iliac region by means of cellular tissue.

Bardeleben, in 1849, from an examination of one hundred and sixty cadavers, asserted that the cæcum was completely surrounded by peritoneum; also the celebrated anatomist

Laschke, in 1861, declared that in the fœtus the peritoneum surrounds entirely the cæcum and appendix, and that the same condition prevails as a rule in adult life.

The assertions of these two distinguished anatomists, however, attracted little attention, and it was not until Frederick Treves, in 1885, from an examination of one hundred bodies, most positively asserted that the cæcum is entirely covered by peritoneum; that this view became the generally accepted one, both by anatomists and surgeons.

In the eleventh edition of Gray's Anatomy, published in in 1887, the reflections of the peritoneum as given by Treves are adopted, with the statement that they are unquestionably correct. This being true, the term paratyphlitis is evidently anatomically incorrect, as all inflammatory processes arising from either appendix or cæcum must primarily be intra peritoneal.

The appendix vermiformis is attached to the lower and back part of the cæcum. It is a long, narrow, worm-like process, usually coiled upon itself, measuring from three to six inches in length, and about the size of a lead pencil. It terminates in a blunt point and its canal communicates with the cæcum by a small orifice, which is often guarded by a fold of mucous membrane called Garlach's valve. The coats of the cæcum and appendix are the same as those of the large intestine. The mucous membrane, however, has a greater number of solitary glands, and in the appendix there are many Peyer's patches. The appendix is entirely surrounded by peritoneum, which generally forms for it a mesentery. Its direction is usually upwards and inwards, behind the internal border of the cæcum or lying on the mesentery of the ilium.

The usual position of the cæcum as stated, is lying on the psoas muscle, with its apex just projecting over its internal border (Treves), although this may be said to be its usual position, its actual position as well as its mobility in any given case depends on the height of the reflection of the peritoneum from the ascending colon, and on the existence and length of the ascending meso-colon.

In a case which I recently examined post-mortem, the cæcum was found resting on the bladder, its apex not more than

one inch from the symphysis pubis. The appendix was hanging free in the pelvis. In this case the cæcum could be made to touch almost any part of the abdominal cavity. Treves states that in eleven of the one hundred bodies he examined, the cæcum could be made to touch the under surface of the liver and any part of the left side of the abdomen, and in seven instances it could be drawn down the thigh as far as the great trochanter. The reflection of the peritoneum from the posterior surface of the cæcum on to the posterior abdominal parietes corresponds to the commencement of the ascending meso-colon.

In the post-mortem examinations that I have made, there have been found three principal folds formed in the reflection of the peritoneum, which are shown in their respective cases on raising the cæcum. In the first and most frequent, a fold of peritoneum is seen reflected from the ascending meso-colon along the line of the psoas muscle, forming the external boundary of a distinct fossa, which is bounded internally by the reflected mesentery from the terminal portion of the ilium. In this fossa would be found the appendix. The mobility of the appendix will depend entirely on the length of its mesentery.

In the second class of cases, the reflection of the peritoneum would follow two distinct lines; one, the internal fold would be as before, along the border of the psoas muscle, and the other, the external, would be from the external border of the ascending colon outwards towards the anterior superior spine of the ilium. In this very distinct fossa directly underneath the cæcum would be found the appendix, probably entirely hidden from view unless the cæcum was raised.

In the third class of cases, the reflections of the peritoneum from the meso-colon would be in a fold along the external border of the psoas muscle, and the appendix would be found external to this fold, or along the outer border of the cæcum.

In six cases recently operated on by McBurney, he reported finding the appendix in two of them in this position.

The appendix may, however, be found in the pelvis in contact with the sigmoid flexure, rectum, uterus or bladder. The fossæ described as produced by the reflections of the perito-

neum from the commencement of the ascending colon, are called iliac fossæ and are of great surgical interest, as small collections of pus or the appendix may be circumscribed or bound down by adhesions in one of them and thus hidden from view.

In accordance with former anatomical teaching, that the posterior portion of the cæcum and a part of the appendix were not covered by peritoneum, it was also naturally taught that the perityphlitic abscess was extra-peritoneal. Now, on the contrary, it is known that these abscesses are primarily always intra-peritoneal and only become extra-peritoneal, if they do so at all, by the extension of the suppurative process.

ETIOLOGY.

The frequency with which inflammatory action is established in the appendix and cæcum must very largely depend on their anatomical arrangement, the small intestine opening into the large would in consequence of the disparity in size of the two segments, tend very materially to produce stagnation of fæcal matter at this point. Added to this is the fact of the cæcum and appendix being placed below the entrance of the ilium, below the natural fæcal current. They are, indeed, pockets most favorably placed for the lodgment and retention of fermenting fæcal matter, foreign bodies and pathogenic germs. This lodgment and retention of fæcal material is productive of mechanical irritation, catarrhal inflammation, superficial tissue, necrosis, septic inflammation and ulceration which leads or may lead to gangrene or perforation.

Treves says that the appendix is obsolete and out of date, and it is safe to predict that in the intestine of the man of the future there will be no such process found hanging from the cæcum. Sex and age play a very important part. Three-fourths of all cases occur in males. In 1030 cases collected by Matterstock, 63 per cent. occurred between the ages of eleven and thirty.

The fold of mucous membrane placed at the entrance of the appendix contracting its orifice, is most prominent during adult life, at the age that appendicitis is most frequent.

Gerlach, whose name this valve bears, believes that it, by

constricting the orifice of the canal, hinders the expulsion of materials from the appendix, and thereby favors inflammation and perforation.

Constipation and intestinal catarrh in producing fæcal concretion and retention of fæcal material in these parts, unquestionably plays a most important part in typhlitis and appendicitis. Tubercular, typhoid and dysenteric ulceration may lead to perforation of the cæcum or appendix. Matterstock has collected one hundred and forty-six cases of perforation of the appendix, in sixty-three of which concretions were found, and in nine cases foreign bodies. Fitz, in one hundred and forty-two cases in children and adults, found fæcal concretions in forty-seven per cent., and foreign bodies in twelve per cent. The concretions may be composed entirely of fæcal matter and be soft, or they may be in part composed of phosphate or carbonate of lime and hard, or they may have one of the various fruit seeds for a nucleus. Among the foreign bodies producing perforation, the seeds of fruits are the most frequent. Cæcal stones containing calcareous matter and very hard are mentioned by Albers and others as having produced perforation of the cæcum.

TRAUMATISM.

In one hundred and one cases out of two hundred and nine, external violence immediately preceded the attack (Fitz). The lifting of heavy weights, a fall, violent exercise and overeating are frequently supposed to be causes.

PATHOLOGICAL ANATOMY.

The primary changes in the appendix or cæcum from fæcal concretions or foreign bodies, are first, mechanical irritation leading to catarrh. The process may stop here, or the cause being continued, there will be superficial necrosis of the epithelial layers, affording an excellent opportunity for the invasion of pathogenic germs. The extent and rapidity of the process will depend on the number and virulence of these germs, or their ptomaines. In the worst cases, gangrene of the entire appendix without limiting adhesion, and with the symptoms of severe sepsis may occur, or a large perforation may be produced, followed by acute general peritonitis, limit-

ing adhesion not having formed. In less acute cases, limiting adhesions are formed from a fibrinous exudate surrounding the appendix, or a perforating ulcer of the cæcum, and shutting off the general peritoneal cavity. In this way a circumscribed perityphlitic abscess is produced. In cases where the germs are less virulent or fewer in number, and these are probably by far the most numerous cases, the exudate on the adjacent surfaces of the peritoneum remains plastic without the formation of pus. This exudate may bind down the appendix, producing twists or kinks in its lumen. Often in consequence of interstitial inflammation, its canal is much narrower, or even obliterated in whole or in part—as a result of this partial obliteration, retention cysts are often produced.

In relapsing appendicitis there is usually some stenosis of the canal, associated with a catarrhal inflammation and a plastic, localized peritonitis. The tendency to the formation of pus in these cases is very slight, although recently McBurney has reported one such case, and Abbe two. Nature's methods of cure in perityphlitic abscesses are very various. They frequently discharge into the cæcum, or may discharge into the small intestine or rectum, with good results. The bladder is occasionally perforated, a fæcal cystitis with fatal result usually occurs. They often discharge through the abdominal wall, and in children at the umbilicus. An abscess placed on the outside of the cæcum may extend upwards to and behind the liver, producing a sub-diaphragmatic abscess. When in this situation it may perforate the pleura.

These abscesses are primarily always intra-peritoneal, but by an extention of the suppurative process, they may penetrate the posterior parietal peritoneum and become extra-peritoneal or perityphlitic. In this situation behind the cæcum they can extend upwards to the kidney, producing a perinephritic abscess, or following the psoas muscle point beneath and below Poupart's ligament. The pus may find an exit through the obturator foramen forming an abscess under the gluteal muscles or on the thigh, or enter the hip-joint, or follow the rectum and become a peri-rectal abscess. Powell reports a case where the abscess communicated with the internal iliac artery, and Bryant a case of communication with

the deep circumflex artery. The two most fatal extensions of perityphlitic abscesses are, first, perforation into the general peritoneal cavity producing acute diffuse peritonitis. This occurred in six of thirty cases reported by Wythe, and in eight out of sixty-seven cases reported by Bull. Second, an extension of the inflammation to the ilio-cæcal vein, with the result of producing a septic phlebitis of this and the portal vein and abscesses of the liver. This is not a very uncommon and a most fatal result.

SYMPTOMS.

Typhlitis stercoralis is usually a chronic affection with a history of constipation, alternating perhaps with occasional attacks of diarrhœa, and attended with colicky pains in the ileo-cæcal region. The general health is somewhat disturbed, occasionally there are acute exacerbations, the pain is increased, there may be fever and vomiting. The patient is disinclined to exertion, as it increases the pain; the appetite is poor. The most important signs are gained from a physical examination. The bowels are usually distended with gas. In the cæcal region at the commencement of the attack, will be found a tumor slightly sensitive on pressure; large, extending up towards the liver and of a doughy feel. Typhlitis stercoralis may advance to perforation of the bowel, attended with the acute symptoms of a perityphlitis, but this result is very unusual. Its symptoms are usually mild and its course chronic. It should be differentiated from acute appendicitis as well as from acute perforating ulcers of the cæcum. It is now well established that the great majority of inflammatory and suppurative processes in the right iliac fossa have their origin in the appendix.

Appendicitis has occasionally a prodromal stage. Its symptoms are colicky pains, with irregularity of the bowels, pains after eating and a variable appetite. An acute attack is ushered in by sudden severe agonizing pain starting from the cæcal region. It may radiate through different parts of the abdomen, or the pain may be at first general or more intense at the umbilicus. The pain may be very severe during the first day or night and then gradually subside, leaving only sensitiveness on pressure over the cæcum; or the pain may come

on gradually, and constantly increase during the course of the disease. There is usually nausea and vomiting, at first the contents of the stomach are ejected, afterwards bile, but never stercoraceous material. Disorder of the stomach is more constant and severe in children than in adults. There is loss of appetite, the bowels are usually obstinately constipated, although constipation may alternate with diarrhœa. The temperature generally ranges from 100 degs. F. to 102. The pulse is accelerated, ranging from 100 to 120. In children, convulsions and delirium may be present.

The physical signs are very important in making a diagnosis. At first there is slight tympanic distention of the bowels, without dulness. The abdominal muscles on the right side are tense. There is increased sensitiveness in the cæcal region, and firm pressure increases the pain. McBurney has pointed out that on a line running from the anterior superior spine of the ilium to the umbilicus, and two inches internal to the spine, finger tip pressure will always elicit pain. This point varies somewhat with the location of the appendix, but nevertheless the sign is a very valuable one.

A tympanitic dullness is usually observed over the cæcum after the third day. In thirty-seven cases of typhlitis, appendicitis and perityphlitis, Fitz records dullness as occuring on the first day in two cases, on the second in two, on the third in eight, on the fourth in nine, on the fifth in three, on the sixth in two, on the seventh in two, on the eighth in five, on the ninth in one and on the tenth day in three cases.

As regards the first appearance of a tumor, the same author found that palpation showed the presence of a tumor in ninety-two cases as follows: on the first day in five cases, on the second in nine, on the third in twelve, on the fourth in twelve, on the fifth in seven, on the sixth in eleven, on the seventh in eight, on the eighth in eight, on the ninth in eleven and on the tenth day in eleven cases. Fluctuation not occurring until after the second week, is of no special diagnostic value.

DIAGNOSIS AND DIFFERENTIAL DIAGNOSIS.

The diagnosis of perityphlitis is as a rule comparatively easy, but that it may be at times extremely difficult and some-

times well nigh impossible even in the most skilled hands, is sufficiently attested by the numerous autopsies or operations performed, where there was a failure to make a correct diagnosis. This may in a measure be accounted for by its variable symptoms, as well as from what may be termed the unnatural location of the cæcum and appendix, due largely to the mobility of the cæcum. However, if the cardinal symptoms are kept well in mind, one will not be long in coming to a correct diagnosis in any given case.

The most important and most constant symptoms are sudden severe pains in the cæcal region, attended with fever and vomiting, tension of the muscles and increased sensitiveness on pressure over the cæcum, and the finger tip pressure pointed out by McBurney, with constipation, and often on the third day, a tumor.

The diseases most likely to be mistaken for perityphlitis are peritonitis, invagination, intestinal obstruction, psoas abscess, perinephritic abscess and hip-joint disease.

Peritoneal inflammation originating in other parts of the abdominal cavity, then the right iliac region, is as a rule, not of appendicular origin; while peritoneal inflammations, having their starting point in the cæcal region, especially in man, are almost invariably due to disease of the appendix. In invagination there will usually be found a movable tumor in the left side, without fever for the first days, and attended, especially in children, with tenesmus and bloody discharges from the bowels.

In strangulation, vomiting is most obstinate and becomes stercoraceous from the third to the fifth day. Constipation is absolute beyond the contents of the large bowel. There is no fever until commencing peritonitis. The disease affects the system more profoundly than does a case of perityphlitis. Psoas abscess may compare in position to a perityphlitic abscess, but its course is chronic, of slow development, attended with disease of the spine; fluctuation can usually be made out, the abscess is sub-peritoneal, following the course of the psoas muscle and pointing below Poupart's ligament.

In peri-nephritic abscess, the disease is located in the groin and is usually associated with pus in the urine.

HIP-JOINT DISEASE.

Under ordinary circumstances, it would seem inexcusable to mistake these diseases, still Gibney reports four cases of perityphlitis being mistaken for hip-joint disease. In acute cases, all that they will have in common will be fever and flexion of the thigh, with pain on extension. In cases of hip-joint disease that has gone to perforation of the acetabulum and the formation of an iliac abscess, the disease will have been of weeks or months duration. The tumor will be lower down nearer Poupart's ligament, will often fluctuate and being sub-peritoneal, will tend to point below Poupart's ligament. The prognosis in any given case of appendicitis will largely depend on the acuteness of the process, the size of the perforation, if one takes place, and as to whether suppuration is established or not. In very acute cases with gangrene of the appendix, the result will probably be always fatal without timely interference by operation. In perforation without limiting adhesions producing acute general peritonitis, the result has been almost invariably fatal. Although Dr. Abbe has recently reported that he has cured two cases of acute general peritonitis by making an opening in each groin and keeping up constant irrigation.

According to Fitz's tables, thirty-two per cent. undergo resolution without the formation of pus, and in eighteen per cent. with the formation of pus, spontaneous evacuation takes place, leaving fifty per cent. dependent on operation. There can be no doubt but what very many cases of appendicitis are recovered from, without the condition ever having been diagnosed. In many cases the post-mortem table reveals evidences of previously existing appendicitis from which the patients had recovered without having been aware of the disease from which they suffered. Toft, in 300 autopsies, reports that 36 per cent. revealed evidence of disease of the appendix. Also Dr. Ludwig Hexton (Bridge) in 280 autopsies found in 15 per cent evidences of previous peri-appendicitis from which the patient had recovered.

TREATMENT—MEDICAL.

There is still some diversity of opinion in regard to the medical treatment of perityphlitic processes. On one point all are agreed that in stercoral typhlitis, the bowels should be thoroughly evacuated either by purgatives or enemata, or by both.

In that form of perityphlitis caused by inflammation or perforation of the appendix, the majority of authors discountenance the use of both purgatives and enemata, holding that by their use the recently formed limiting adhesion will be rendered liable to rupture in consequence of the increased peristalsis. These physicians give opium in sufficient quantity to allay pain, produce sleep and hinder the peristaltic action of the bowels, hoping thereby to favor the formation of limiting adhesions. Among the physicians recommending the above line of treatment may be mentioned Fitz, Matterstock, Wythe, Volz, Stokes and Graves, Loomis, Whittaker, Flint, Strumbell and Jacobi.

Meigs and Pepper give mild salines, with opium for rest. Silberman gives in children hydrate of chloral instead of opium, Monti uses irrigation of the bowels with purgatives.

DEPLETION.

The German physicians as a rule, such as Nothnagel, Strumpell and Matterstock use leeches or wet cups, followed by the ice bag, Bull uses leeches, Balzer and Gibney recommend blisters.

Warm poultices or hot compresses are much used in this country. Their use, although in a measure allaying pain, is extremely questionable, unless for the purpose of aiding or hastening suppuration. The diet should be liquid and absolute rest be maintained. During convalescence also, the greatest circumspection should be exercised both as regards diet and exercise.

Nearly all cases are primarily medical. Just where and when the distinction should be drawn between medical and surgical cases is still a matter of dispute.

Stercoral typhlitis will undoubtedly always remain medical. Cases of plastic appendicitis without the formation of pus

and without severe recurrences will remain medical. The recurrent cases of catarrhal appendicitis will be medical until it is shown that the recurrences are sufficiently often and severe to affect the general health and to prove disabling, then they will become surgical. Cases of acute gangrene of the appendix should always be surgical, as well as cases of acute perforation without limiting adhesions, although there is still some contension over the suppurative cases, nevertheless the practice of treating all cases in which pus has formed as surgical, is fast becoming the recognized rule.

e cases demanding operation may be divided into three
s. In the first will be the extra-acute cases. The
tion is done for the removal of either a gangrenous or
rated appendix. The symptoms are alarming and
ten either general sepsis or general peritonitis. The
tion is done on the second or third day, and is preven-
n its scope, little or no pus will be found, and often by
ninal palpation, no tumor will be made out. The in-
n must be a long one, from four to five inches, and placed
the most sensitive point determined by finger tip pres-
this will be over the cæcum. The peritoneal cavity is
arately opened and search is made for the appendix. It will usually be found inclosed in a quantity of recent exudate forming a small tumor, in which there may be a small amount of pus. This tumor should be carefully surrounded with sponges or sponge cloths before being broken into, so as to catch and remove every particle of pus, thereby preventing
tion of the general peritoneum. After being thus sur-
ded, it is broken into, the pus removed, the adhesions
ing down the appendix broken up, the appendix ligated
its junction with the cæcum and cut away. McBurney
tices disinfecting the cæcal extremity by means of the
ery. The small cavity is then carefully dried with
ges and packed with iodoform gauze, the strip being
ght out of the wound, which is partially closed, and an antiseptic dressing applied. The dressings are changed every two to four days and the healing is complete in about a month.

At the present time this operation is confined to the extra-

acute cases, where it would be extremely hazardous to wait for limiting adhesion. It is distinctly an American operation, brought forward and perfected by the genius and skill of American surgeons. The results even in most desperate cases have been thus far most gratifying.

In the second class of cases, the symptoms, though acute and pronounced, are more indicative of a localized peritonitis. In these cases the operation is usually deferred until from the fourth to the eighth day, after a tumor and limiting adhesion have formed. The incision, some two inches long, is made directly over the most prominent part of the tumor, and on reaching the tranversalis fascia, it has been quite the rule to use the hypodermic needle with the view of locating the pus or ascertaining if any existed. The procedure is now not very generally in use, for the reason that pus may be present even in considerable quantity and the needle fail to show it. But a few days since I assisted at an operation for perityphlitis where the needle was used, but failed to show pus, and on incising the peritoneum a liberal quantity of pus was discharged. Sands was the first to draw attention to the possible dangers of the needle, in that it might perforate coils of adherent intestine before entering the abscess cavity, and on being withdrawn, infect the peritoneum. I recently operated on a case in which adherent coils of intestine were encountered directly beneath the peritoneum, over the most prominent part of the tumor. On separating these and some recent adhesion to the cæcum, at least one-half of a pint of pus was liberated from an abscess placed directly underneath the cæcum. In this case it would have been anatomically impossible to have reached the pus with a needle without first perforating at least two or more coats of intestine. It has also been recommended after locating pus with the needle to leave it in sight as a guide, and cut down on the pus along the needle. Should the needle have perforated one or more coils of intestine, the result would not be gratifying to the surgeon.

If the peritoneum is incised and pus is not found directly beneath it, the wound must be enlarged, the adherent coils of intestine carefully separated with the fingers towards the

center of the tumor until pus is reached. If the appendix is found lying loose in the abscess cavity, it should be ligated and removed. If it is adherent, it should not be disturbed; only the gentlest manipulation in the abscess cavity is permissible, as several cases are on record of rupture from manipulation into the general peritoneal cavity and death.

The abscess cavity is usually irrigated with some mild antiseptic solution, a drainage tube introduced and a large antiseptic dressing applied.

RECURRENT APPENDICITIS.

The medical treatment is confined to regulating the bowels, the diet, and the exercise and giving opium for pains.

Treves was the originator of the operation for removal of the appendix between the attacks in cases of recurrent appendicitis. In suitable cases the operation is generally recommended, although Frederick S. Dennis, in an elaborate article in the *Medical News*, opposes it, and contends that if an operation is to be performed it should be during the attack. The majority of operators, however, followed Treves. The indications for the operation are severe recurrent attacks producing invalidism. The operation is performed in the usual way with a rather long incision over and parallel with the cæcum. The appendix is separated from its adhesions, tied and removed, or after being incised its end is closed with a row of Lambert's sutures. The wound is closed without drainage. The mortality has been almost *nil*, and the results most gratifying.

ACUTE ANGINA FOLLOWING THE USE OF SALOL.—Morel-Lavallee records the case of a young woman, a syphilitic, who, having otorrhœa, was treated by insufflations of salol. Three days after, fever appeared, with enormous swelling of the external auditory canal, the isthmus of the fauces, and of the uvula. In three or four days these symptoms disappeared. The cause of the trouble was, according to the author, the decomposition of the salol into its two component parts, which was brought about by the presence of a fatty substance.—*Archives Internationales de Laryngologie*, 1891, p. 140

REMARKS ON THE NATURE AND TREATMENT OF TUBERCULOSIS.*

BY E. L. SHURLY, M. D., DETROIT, MICH.

Mr. Chairman, Ladies and Gentlemen—

I regret very much that I have not a written paper for this occasion, as I intended to have. I shall therefore have to ask your indulgence for the deranged manner in which the subject will be presented.

As I understand the topic I am expected to speak of, it is "The Nature and Treatment of Tuberculosis." Of course, such a subject is of too wide a range, and will take up too much of your time for this occasion, and I shall therefore condense very much what I want to say, leaving out almost entirely any remarks upon pathology, which is very important and interesting.

Allow me to say first, that I think a great deal of confusion arising at the present time over the subject of tuberculosis, comes from lack of recognition of the several different states of the disease met with. There is no doubt but that it will be a long time before all the problems connected with the subject can be solved, and that many theories will have to be evolved. We are in the habit of sneering a little bit (if we be practical people) at the theories. After a l it is theory which must lead to the practical solution of all such questions.

Now, the prevalent theory is the bacilliary one; that is, that the bacillus tuberculosis is the cause of all these several different states known as tubercular disease. We heard this morning a very excellent paper on tuberculosis of the joints, by Prof. Nancrede, a very philosophical and instructive paper, and you will remember that the author spoke of the bacilliary action in the production of tuberculosis of the joints, although he did not insist upon it as inevitable. There are other surgeons who believe that the bacillus tuberculosis has nothing whatever to do with such diseases of the joints. There are still others who do not believe that many of these

*Read before the Michigan State Medical Society, Flint, 1892.

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kinds of tubercle bacilli. In a
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transferred with the microbe some unformed or active ferment, either the product of the bacillus or extraneous to its life.

And therefore we do not know how much or how little the disease process depends upon the ferment which is transferred with the microbe or the microbe itself. Hence, I believe that in the present state of our knowledge, it is unsettled whether the microbe or bacillus is the only cause of the diseased condition generally classed as tuberculosis. I also believe, and I think the drift of opinion is in this direction, that there are distinct clinical and pathological differences in these cases. For instance, I do not think from a clinical standpoint that so-called tuberculous joints, so-called tubercular pulmonary disease, leprosy, lupus and tuberculosis of the peritoneum are identical diseases. I do not believe they are one and the same disease, although they may be closely related in some particulars. That brings us then to the practical consideration of the classification of such diseases. Every practitioner knows that there are certain forms or cases of disease, which he is unable to classify exactly by physical signs or by clinical history, and that there are certain differences clinically, no matter what identity laboratory examination may show regarding them. Some of these variations may be accounted for partly by the individual tendency to peculiarities, individual idiosyncrasies, but such consideration is not sufficient to account for the regular course of special cases. For instance, we have a case where there is no hemoptysis, where the cough comes on gradually but is a first symptom, while pyrexia and adynamia come on later and progressively, and after a while expectoration, etc. Upon physical examination of the chest we find that there is gradual consolidation taking place in the upper part of one lung, and perhaps some lesion in the other lung, all of which progresses, the patient dies, and if an autopsy is made, there will be shown the ordinary morbid anatomy of a case of pulmonary tuberculosis. The course may cover a period of several months, a year or more. Yet another form will cover a period of several years. Still another form, the mechanical, such as miners and grinders are afflicted with, where a great

many years are consumed in the course of the disease. And again, another very decided form, where the course is very rapid but differing from acute miliary tuberculosis in this respect, that the lesion initially and all the time is confined to the lung; after a little time the whole pulmonary tissue seems to liquefy. Such cases are typical. You will all recognize them. We meet with them frequently, but they are not one and the same thing, and moreover it does not change the result whether the family history be bad or good always, but if the domestic history has been good or bad, it may modify the course of the disease. These cases then are so frequently typical that we must recognize them at least as varieties of pulmonary disease; in all of these examples mentioned, the lungs have been the seat of the principal lesion, therefore, they must be cases of phthisis. Now, we believe that all of such cases of so-called phthisis pulmonalis are essentially inflammatory; that the tubercular process is a secondary one. That the majority are ordinary catarrhal pneumonias, and whatever of tuberculosis comes, is secondary. This view, however, does not militate against the prevalent theory of the bacilliary origin of tuberculosis or phthisis pulmonalis, inasmuch as it is said by every one that there must be a nidus for the germs to grow upon. Why they do not always occur and develop in all cases of catarrhal inflammation of the air passages is a mystery. However, we know as a fact they do not. Allow me for a moment by way of diversion to call your attention to laryngeal phthisis, one of the most horrible diseases that can affect the human being. This disease as you know is very obstinate. It appears in two general forms, and has peculiar features. There are very few cases of laryngeal phthisis which are secondary to pulmonary tuberculosis. It is often coincident to pulmonary disease, it is true, but it is not often secondary. Yet what a large number of cases of pulmonary phthisis occur without any laryngeal complication whatever, without laryngeal phthisis. Is it not strange?

In chronic laryngitis, even with erosion, no pulmonary phthisis, no tuberculosis necessarily follows. Why should this be, if the bacilli are constantly travelling this track,

and only waiting for a little opening good ground? Hence there must be other etiological factors to be taken into consideration in any description of the nature of this disease, called pulmonary phthisis. To sum up, I should be inclined to think that the nature of pulmonary tuberculosis or pulmonary phthisis was essentially inflammatory in the beginning, whatever subsequently may follow. This view does not seem unreasonable in the light of clinical history, but I admit it may seem unreasonable in the light of laboratory experiment as conducted at the present day. Deduction from these, however, are undergoing great change. If it be true that common phthisis pulmonalis be an inflammatory affection, it gives us some encouragement toward endeavors to mitigate its inevitable course and result. On the other hand, if it be always specific, dependent upon the invasion and operation of bacilli alone, then there is no hope. Regarding treatment, which has been generally unsatisfactory, we find many difficulties.

At the outset in almost all cases, one of the most troublesome symptoms we meet with is anorexia, which precludes the establishment of any sort of nutrition for the benefit of the patient, and which constitutes one great drawback to all treatment. Perhaps I am a little ahead of my story, for I ought to specify that we have three classes of cases to deal with: acute, sub-acute, and chronic. That is excluding what is called miliary or general tuberculosis.

But anorexia is common to all, and one of the first difficulties to be overcome and thought of. Those of us who have had large experience with these diseases, become very much discouraged in attempting to keep up the nutrition of the patient on account of this symptom, especially if we are obliged also to administer by the stomach all sorts of medicines and oils, etc. But this has been the ordinary mode of treatment-the applications of medicines in the usual way, by the stomach. And we know how very few patients will tolerate it for any great length of time without greater increase of anorexia; this is especially true of the cough balsams and syrups and oils. Therefore, it seems very desirable to adopt any method of which medication may be useful outside of

stomachal. Now we have two things before us in this direction, one is climatic treatment and the other is by means of inhalation or hypodermic medication, or both. Climatic is so efficacious and well known that I need not speak of it here. I would remind you, however, as a proof that the bacillus is not the only cause of the diseases in question, that this microbe will operate just as well in Colorado and California as in Michigan, notwithstanding the claims of enthusiasts that the atmosphere of the former States is a septic, and if not indigenous there they are taken there, and probably flourish, since cases of phthisis pulmonalis or tuberculosis originate there and run the same course just as in Michigan. But outside of this we do know that a favorable climate is one of the most useful factors in treatment, for by putting the patient in a position to get plenty of fresh air, oxygen (as necessary as other nutrition) by putting him in the way of receiving plenty of heat and light, and the benefit of the actinic rays of the sun together with dry atmosphere, he is undoubtedly placed in a position of great advantage.

Regarding medication, we consider of first importance the hypodermic method because the medicine is introduced into the system in its pure state, undergoing no change by contact with the secretions of the stomach or intestines, besides whatever good it does in a selective way, the system may get the full benefit. This we believe is the preferable way, whether the disease be much localized in the lung or not. Notwithstanding particular localization, there is always spontaneously generated from this source a certain amount of septic poison, so that cases of phthisis pulmonalis are essentially forms of septic cæmia, a general septicæmia of some sort induced by the circulation of some toxic material which poisons the tissues generally. This seems perfectly rational, and ought to be very generally accepted. Now, if we can introduce something into the economy that will neutralize the septic material, of course we take a step forward. It is claimed by many that nothing but a colloid substance—organic—can be expected to act permanently in this way to neutralize an animal poison. We have not time to go into this question, which together with a great many other such ques-

tions may be relegated to the chemist, who in the near future must settle many mooted points of pathology. I will only say that this is certainly not borne out in practice. For we may introduce an alkaloid into the general system with as much hope of its producing a permanent, prompt and selective effect as though it were colloid; it is not necessary, then, that it be an animal poison. However, while we can produce such effects from an alkaloid just as well as a colloid, the effect is not as lasting because there are no secondary or multiplication effects excepting upon the nervous system, so that the injections must be repeated.

Therefore, I still believe that is the proper and rational method of systematic treatment. We prefer iodine and chloride of gold and sodium, but perhaps the use of iodine and chloride of gold and sodium may not be the best chemicals. There may be found some others that will answer the purpose better; undoubtedly there will be. But these two chemicals have done much good in pulmonary phthisis of the earlier stages. But of course they are not capable of controlling the septicæmia which occurs in a large class of cases. Take, for instance, a case showing evidence of tuberculosis affecting the mesenteric glands as well as the lungs, it is very difficult to put enough of any chemical into the system without getting a toxic effect, to neutralize it. Besides this method, we may be able to modify the source of poisoning by proper inhalations—antiseptic inhalations of some sort—when there are patches of caseation that are accessible to the bronchial tubes, by the use of some gas which can reach that part. In this way a cutting off of the source of septic material may be obtained, and for that reason different gases have been used from time to time. Chlorine gas has been used at different times, but abandoned because irrespirable. However, it has been found practical for inhalation when properly used, mixed with salt spray, and the cases properly selected for it. We may use also the antiseptic balsams for the same purpose. These not only have a local effect in quieting the immediate symptoms known as cough and so on, but certainly have the ulterior effect of cutting off the supply of septic material. So that, so far as the therapeutic indications are concerned, there seems

to be two—one to limit the extension of the disease, and the other to neutralize the septic material that is being generated from hour to hour in the course of the disease.

One thing that for many years has given me great hope that we might achieve something in the treatment of phthisis pulmonalis is, that a great many of the local changes, the pathological changes, which take place in the lung are really conservative. They are nature's efforts to limit the disease and to throw off the *materies morbi*, whatever it may be.

I don't think I will take up your time in giving the history of cases *in extenso*. I would simply like to mention two or three illustrating the remarks. For instance, one case that I have only a synopsis of, is as follows:

Mr. S., age 37, farmer, German; father and grandfather died of phthisis. One year before entering hospital he had bronchitis, and for six weeks was quite sick with it; but finally grew better. He has had cough ever since, with expectoration increasing until it became abundant and heavy. When he was admitted to the hospital his pulse was small and rapid, 120, temperature, 101.5°. There were tubercle bacilli in sputum in great quantities. He was put upon a treatment of hypodermic injections of iodine, commencing with one-sixth grain, which was rapidly increased to a grain and a grain and a half, together with chlorine inhalations.

The physical signs showed the upper half of the right lung more or less consolidated, as shown by bronchial respiration, increased fremitus, brouchophony, and dullness on percussion. This condition extended down to about the fifth rib in front and behind. The respiratory murmur on the other side was exaggerated. Now this is a type of case commonly met with—a case of phthisis beyond incipiency. This man also had a bad family history. The temperature and pulse range gradually, but quite rapidly, diminished under the treatment, so that at the end of the second week the evening temperature did not go beyond 99.6° and the pulse subsided to 90; at the end of the fourth week the evening temperature ranged at 90°, and the pulse at 84, and there were no other exacerbations through the day. There had been a return of appetite, and all the physical functions were being performed very well.

This man was in the hospital about eight weeks; he went home last week. Now, you can't say that the man is well. He may have a relapse, and some more inflammation of the lungs, and he may have tuberculosis yet, but I do not believe that his was a case of tuberculosis. I believe the diagnosis between phthisis pulmonalis and tuberculosis must be made by some other method than those in vogue now. We shall have to take into consideration other characteristics of the sputum besides bacilli. We have already found that in some cases there are certain precipitates from the sputum which will kill animals directly, while the precipitates obtained with the same re-agents from other cases will not kill animals. Whether this arises from some deflections by chemical manipulation, or whether there is some peculiar toxine we cannot say. As it occurs so uniformly, we believe that there must be something in it of importance before we can arrive at the proper diagnosis, prognosis and classification of these diseases. In all probability we shall have to call in the aid of a chemist to examine chemically the expectoration, and trust as now to the staining of bacilli.

Another case I will relate, where a man was under treatment three years ago, who seemed apparently to recover, although throughout the course of his disease he had some looseness of the bowels, showing some intestinal disturbance; he improved and left the hospital after two months. He returned six weeks ago very much worse. He seems to be getting better again, although there is diarrhœa and tenderness of the abdomen. Now, the probability is he will not recover under the treatment. He had also a bad family history. Now, whether this case is of a different nature, really a tuberculosis or a general glandular degeneration or not, we cannot say. I could relate another case, if there were time, bearing on the paper of the gentleman who preceded me—a case we now have in the hospital of general tuberculosis, probably showing no lesions in the lungs. The physical signs show no consolidation. Respiration is simply rapid from pyrexia. We are unable to make the diagnosis exactly. We simply know it is not typhoid fever. The man is rapidly going to his death; there seems to be no lesions discoverable

by auscultation in the chest, which will at all account for the patient's condition. Neither are the abdominal lesions sufficient to account for the great pyrexia and adyramia. It seems to be a systematic infection.

A case of this sort should be classified not as a case of phthisis pulmonalis, as is generally done. It is undoubtedly a case of tuberculosis. Therefore, I believe, that adopting the idea of phthisis pulmonalis being essentially a local inflammatory affection, while general tuberculosis is a primary general affection, will very much aid us in getting the true relative value upon therapeutic measures and plans, and enable us to classify these diseases with more propriety than heretofore.

We would direct the attention of our readers to the advertisement of Henry W. Wampole & Co., whose elegant preparations of cod liver oil, compound syrup of hypophosphite, and tasteless cascara bark, have of late received such an amount of justly merited praise. This altogether reliable house is to be congratulated upon the success they have acheived, and to our readers and the profession at large we cheerfully commend them and their most excellent preparations.

BURNED FLOUR AS A DRY DRESSING FOR ILL-CONDITIONED WOUNDS, ERYSIPELAS, ETC.—Dr. J. J. Crow, of Carrollton, Ill., writes: "I have lately used common flour burned in a stove-pan as a dressing for erysipelas, senile gangrene, and burns, and am much pleased with it. It is almost everywhere present, and may be prepared in a few minutes. It is cheap and may be impregnated with iodoform, aristole, or other antiseptics. I hope the profession will give it a fair trial. It is, of course, finely divided charcoal.—Ex.

TWIN PREGNANCY.—ONE FŒTUS IN UTERO AND THE OTHER EXTRA UTERINE.*

BY DR. E. W. MARTIN, FREMONT, NEBRASKA.

Mrs. P., aged 40 years, of Scotch decent, having borne three children and had one premature labor. The eldest child aged 16, the youngest 5 years. A fœtus was prematurely de-delivered three years before the birth of the youngest child. She became pregnant again about the middle of February, 1890. The history of this case proves to be very peculiar.

Nothing remarkable or unusual having been observed in either of her former pregnancies.

On April 30th, I was called to see her, she having discharged her regular physician, by whom she had been attended for several weeks. When I first saw this woman, on superficial examination I thought it a case of septic peritonitis. The vital phenomena were suffering from general prostration and an unlimited degree of pain was manifest. I found her lying upon her back unable to move or be touched; emaciated and suffering great pain in the region of the ovaries, and particularly in the right hip. Absolute constipation had existed for 12 days, accompanied by excessive vomiting. The tongue was coated with a heavy fur in the center and normal color on its edge. She was having considerable metrorrhagia, which had begun a fortnight before. By vaginal and rectal examination, I diagnosed a retroverted, impacted, gravid uterus. By the knee and chest position, after two days effort, I was able in a great measure to replace the organ. Symptoms began to improve, the vomiting ceased, and by a copious injection per rectum, the bowels moved, and with a little encouragement they soon resumed some degree of regularity.

Her appetite returned, and within ten days the patient was up and walking about the house and yard. Immediately upon her effort to be on her feet, her right leg began to swell, and assumed alarming proportions. The foot, ankle and leg to the knee presented marked œdema. With but slight improvement, this state of thing continued until July

*Read before the Nebraska State Medical Society, at Omaha, May 12th 1892.

18th, when I was suddenly called, and found her with all symptoms of labor. It should have been stated that at intervals of every five or six hours, slight hemorrhages from the uterus had continued from the time I first saw her until the present. The labor symptoms now continued until the 23d, when a five months fœtus was discharged. The placenta presented the appearance of having been partially detached, which doubtless accounts for the continued hemorrhage. The placenta came away with the same pain that expelled the fœtus, when all pains ceased, followed by little hemorrhage.

For two days I irrigated the uterus with antiseptic lotions. My attention was called by the patient to the fact that she was having quickening, as though another child existed in the uterus. On placing my hand upon the abdomen, I was convinced beyond a doubt that her conjectures were not entirely groundless, as the movements of the child could be distinctly felt at this juncture. However, the patient got up within five days, the swelling disappeared from the limb, she gained in flesh and strength until the 17th of August, when pain began in the region of the right ovary, considerable pain in right hip, back and right limb; gave morphia to relieve pain. By digital examination, or by any other process, I was unable to say whether I had remaining ectopic pregnancy or not. The os was lax and flabby, and although I could pass my finger well up through, I could find nothing within reach, and doubting the propriety of exploring with the sound, I immediately wrote a history of the case and sent it to Dr. Thad A. Reamy, of Cincinnati, Ohio, asking him what he thought I had, whether double pregnancy, with more than one placenta, bifid uterus or extra-uterine pregnancy. If the latter, he thought at this stage it must be of the so-called abdominal variety. He, like Lawson Tait, believed that primary abdominal pregnancy rarely if ever occurred; such cases usually being due to early rupture of the Fallopian tube, and escape of fœtus into the abdominal cavity. He advised me not to explore the uterine cavity, but to watch the case, as he believed it to be one simply of plural uterine pregnancy. Upon this theory I relied for a short time only, when I made my diagnosis—ectopic pregnancy. In the meantime, the or-

dinary symptoms had been going on, unmistakable quickening, placenta soufle, fœtal heart sounds and progressive increase in size. When I made my diagnosis, then trouble came.

Consultation was demanded and the ordinary routine indulged in. Dr. L. B. Smith of my city was called, and three M. D.'s from Lincoln, Nebraska, Drs. Peobles, Mitchell and Griffin. Suffice it to say, the case was so difficult of diagnosis that we were divided, some holding to the theory of a bifid uterus, and others to the ectopic theory. Dr. Peobles was not called until Sept. 25th. On Sept. 26 (next day,) rupture of the sac occurred, followed by collapse. Sept. 27th, at 8:30 P. M., death occurred.

On Sunday, Sept. 28th, I called all who were in consultation, and a post mortem was held, which developed the following: Extra-uterine pregnancy of seven and one-half months gestation, remaining after the expulsion of more than two months previously from the womb a fœtus of an uterine pregnancy.

The development of the two fœti would indicate that conception had taken place at the same time, and from all the circumstances, this theory is the most plausible.

Abdominal action displayed a ruptured chorion, and escape of fœtus and liquor amnii into the abdominal cavity and viscera.

The fœtus was easily removed from among the intestines.

The chorion was found to have many adhesions to both the parietes and viscera. Evidences of an old peritonitis having existed in the region of the right ovary, was patent. The adhesion developed the impossibility of a successful operation of laparotomy being performed at any time after the expulsion of the first fœtus. At no time previous could a correct diagnosis have been made. With a child in utero, no man would have risked his reputation, to say there was another also in the abdominal cavity. Another singular incident now presented itself. The umbilical cord was bifurcated, and led to two placentas. The first of small development, weighing about three or four ounces, had attached itself to the folds of the peritoneum about the left broad ligament. The other

weighing two or three pounds, found its attachments in Douglas' cul-de-sac. It would seem, at the time of conception, that at least one of the ova in its transit from the ovary to the uterus, was arrested in that portion of the Fallopian tube passing through the walls of the uterus; there it became fructified and the development began. This would be called interstitial pregnancy. The post-mortem developed this to be true. As the muscular fibers of the uterus became stretched and distended, it formed the outer covering of the ovum, and accounts for its going to that long period of seven and one-half months before rupture, as it is very susceptible of distention, at least it proved so in this case. A thin layer of uterine muscular fibers was found surrounding nearly the whole of the sack, notwithstanding the fact that it is asserted by some of the most eminent authorities that no placenta having primarily attached itself to the tube or peritoneum, can attach itself to any other structure. How can we account for the firm attachment of the one in Douglas' cul-de-sac. Was that it's primary location? If not, how did it get there? The divisions and sub-divisions of ectopic pregnancy so found in most standard text-books, tend to confuse the medical mind, for such classifications are not sustained by facts correctly observed. It is not my purpose in this paper to speculate or philosophise, but have attempted to give you all the facts, as far as I was able, connected with this most interesting case. So far as I have looked up medical literature, there has been no case reported like it. In conclusion, it is but right to say that our subject closed the life of one of the most elegant and cultivated ladies of the West.

ENGORGEMENT OF THE UTERUS-GONORRHÆ.

I have tried Sanmetto in engorgement of the uterus and found it better than anything I ever used. Also in a case of long standing gonorrhæ which gave permanent relief.

W. C. WOOD, M. D., Woodward, Ala.

Correspondence.

OUR NEW YORK LETTER.

NEW YORK, June 18, 1892.

At a recent meeting of the New York Academy of Medicine, Dr. Paul F. Munde, professor of gynæcology at the New York Polyclinic, read a very interesting and instructive paper on the conservative treatment of salpingitis, in which he stated that he believed the time had come when those who are accustomed to perform laparotomies for the removal of diseased tubes and ovaries must beat a hasty retreat from their present plan of procedure. He is convinced that in the past many uterine appendages have been removed which, by a little patience and perseverance on the part of the physician, might have been saved. This applies in particular to cases of catarrhal salpingitis in which the patient complains of pain in one or both ovarian regions which did not yield promptly to local applications of iodine, etc., and in which the appearance, perhaps, at irregular intervals of a muco-purulent discharge from the vagina denoted the existence of a pyosalpinx. The mere presence of a catarrhal salpingitis, with or without adhesion, the mere presence of a certain amount of pain in these regions, does not of itself demand the removal of the diseased organs. A true pyosalpinx, however—that is, the presence of pus in the Fallopian tubes—calls for its evacuation. If the pus is contained in only one tube and the tube is adherent, Dr. Munde considered it justifiable to aspirate *per vaginam*, and finding pus, to enlarge the incision, wash out the tube, and in this way endeavor to produce obliteration of the calibre of the tube without exposing the patient to the risk of abdominal section. When both appendages are diseased, it is not worth while to resort to vaginal aspiration, but to remove the diseased organs by laparotomy, which is the only correct treatment to follow.

Acute inflammations of the tube are treated by rest in bed, hot vaginal douches, hot poultices, opium and antipyretic

As the case becomes subacute, mild applications of the tincture of iodine, with equal parts of glycerine, may be made to the vault of the vagina, in connection with glycerine tampons and warm sitz baths.

Dr. Hanks agreed with the author of the paper in the principles he set forth, and said we should never perform a laparotomy for the removal of a diseased tube unless we were satisfied that the tube was never to be of any further use to the patient.

Dr. Harrison concurred in the views of Dr. Munde with regard to the too frequency of laparotomies in women. In acute cases of salpingitis, he thought there was nothing equal to the application of ice for the relief of pain and fever.

Dr. Polk approved of the methods presented by Dr. Munde, in the paper that had just been read. The results that have been secured by drainage of the uterus, justified us in believing that it will undoubtedly limit operative cases. The other methods of treatment, such as rest, heat, cold, the application of tampons, etc., are familiar to all, but this one of drainage is by far the most important, and he now employs it in all forms of acute salpingitis.

Dr. Edebohls emphasized the value of ichthyol in the treatment of pyosalpinx. He recommends its use energetically, internally as well as by inunction to the external abdominal and vaginal walls. By its employment, he claims the pain will be relieved more quickly than by massage or electricity.

At a recent meeting of the New York Surgical Society held at the Academy of Medicine, Dr. Gerster presented a woman, 31 years of age, from whom he had removed one kidney while undoubted disease of the other existed. The tumor occupied the entire left side of the abdomen and was but slightly movable. The condition of the patient was very bad. The tumor contained pus which was evacuated by the operation of nephrotomy on March 3d, 1890. Improvement followed, but as elevations of evening temperature still persisted and the discharge was profuse, it was decided to remove the kidney. Nephrectomy was accordingly done on January 31st, 1891. The pedicle was secured by an elastic ligature and the peritoneum shut off by continuous sutures. The wound was treated

by the open method. The ligature came away on the 13th day and the patient made a good recovery; in four months her weight increasing from 99 to 135 pounds.

Dr. Charles McBurney has resigned the chair of surgery at the College of Physicians and Surgeons, this city, and has been succeeded by Dr. R. F. Weir, professor of clinical surgery at the same institution. The appointment of Dr. Weir has given general satisfaction to the students and faculty of the college.

Dr. W. Gill Wylie, in a recent lecture on puerperal fever at the N. Y. Polyclinic, made use of the following language: "I believe now, and I say it with perfect sincerity, that nine cases out of ten of puerperal fever that I am called upon to treat, in from twelve to twenty-four hours after the onset of the attack, I will cure by simply regulating the bowels and washing out the uterus systematically and thoroughly at frequent intervals. If you follow the instructions of the text books, you will find that they advise the washing to be done but once in eight hours. I have proved to my own satisfaction the fallacy of this advice. The germs are not destroyed by the first or the second washing and they develope anew in eight hours. If I am called to a case of puerperal fever, and within six hours or so after frequent washing out the uterus the temperature does not fall to normal, I make up my mind that the poison has entered the tissue of the patient and I at once proceed to open the belly. I generally find there an abscess present."

CLEMIANA CHEMICAL CO., ATLANTA, GA.:

Gentlemen:—Having given the preparation known as verrhus Clemiana a thorough and extended trial, on hospital and private patients, I can most cheerfully recommend it, as serving an excellent purpose in those conditions resulting from specific and scrofulous diseases. I have found it act with almost specific energy in strumous joint diseases of childhood and in many cases of chronic malarial poisoning which have resisted quinine and arsenic. I am yours very truly,

THOMAS H. MANLEY, M. D.,
Visiting Surgeon to Harlem Hosqital, New York.
New York, June 13, 1892.

CHATTANOOGA, TENN.

EDITOR SOUTHERN MEDICAL RECORD:

Dear Sir—In your last issue I read an editorial on "A Growing Evil which should be Remedied," and your suggestions of the remedy, with the natural interest which any physician would feel who has practiced a few years in a place where prescription writing is the rule, because such practitioner will without doubt have been a sufferer to some extent from the very evil you mention. Yet it is the same old story which has been going the round of the medical and drug periodicals, and has been accompanied with much differing and even acrimonious dispute, for years and years. And still the thing continues and grinds along, just as before.

Now the druggist is a great convenience to the busy doctor without doubt, and he relieves him likewise of the necessity of carrying a big cash investment in drugs for office use, and he is not a man we wish to quarrel with. He is our friend so far as mutual trade interests go. But when he adopts the iron clad rule not to refill prescriptions unless directly on order of the prescriber, his business is quite likely to largely fly away to his competitor, because usage at least is along the other course, without necessitating the discussion of its right or error in this article. So we accept the fact as it stands, and look about for relief from the evil, with its attendant injustice to the physician, and liability of injuring the patient or those friends to whom he ignorantly but kindly loans the formula.

You suggest printing the order "not to be refilled," etc., on the blank. But it is a fact that in spite of this instruction, it is more often ignored than observed, like many printed injunctions which we daily become familiar with violating, mainly from the American habit of ideal liberty, which implies resentment of its attempted abridgment. And further, it is a well known fact that the courts have again and again decided (in spite of all arguments by the medical and drug professions that they are severally the owners of this little piece of paper after it is written), that the prescription is the indisputable property of the purchaser, the patient, who has paid his fee for the same. Wherefore the only legal way of protection is by furnishing the medicine in some manner which does not commit the formula to paper. This would mean by verbal direction to the druggist, or by 'phone message, or by speaking tube, etc., all being more or less impracticable. Wherefore it long ago occurred to the writer that in diplomacy, without useless contention over facts as they

exist, lay the remedy, and he applied his reasoning to practice, with perfect satisfaction.

This was accomplished by stocking his office with a small line of drugs, mainly pellets, tablet triturates, and things of small bulk (and it might also be said of small cost and equally small medicinal utility) not for the purpose of medicating the patient as much as for protection of the practitioner. And this done, there is little trouble in making the patient return to your office if his case fails to progress satisfactorily, or he needs repetition of like remedies in the course of future months. How? When the patient receives a prescription from the medical man, he likewise receives a small package of pellets, sugar or milk tablets will answer as well as anything else, but it is best to have a variety of differing forms and colors and sizes of these things, so as not always to use something which the recipient will recognize as given before. Full directions regarding the medicine which is to be obtained at the drug store are then given and equally minute directions follow regarding the use of the remedy handed out by the doctor. The impression is thus made on the patient's mind that both are equally essential to his treatment, and he can but return to his adviser when the little box or paper received from him is exhausted. See? It is the easiest thing in the world, entails scarcely any loss of time, very little outlay, and compasses the practical solution of a problem about which much bitterness has resulted between doctor and druggist and patient, with absolutely not the least ruffling of anybody's feelings. Let those who suffer in this way from the abuse of prescriptions by patrons, just try this method, and they will be surprised how smoothly and how reliably it works, thus demonstrating how much better it is to win by strategy, than to attempt the forced acceptance of a reform which has bitter antagonisms. Very truly yours,

E. A. COBLEIGH, M. D.

It is with pleasure we direct attention to the advertisement of the Bovinine Co., formerly the J. P. Bush Co. Their raw food extract stands alone and is undisputedly the most concentrated and nutritious food extant. After a career of fourteen years, it is now extensively prescribed by the medical profession, because of its material excellence, clinical efficiency and great economy.

Society Notes.

CLINICAL SOCIETY OF MARYLAND.

BALTIMORE, MD., March 18, 1892.

The 264th regular meeting was called to order by the President, Dr. Robert W. Johnson.

DR. W. S THAYER reported a case of leukæmia, and exhibited the patient. The patient, a colored man of about 30 years of age, first reported to the Johns Hopkins Hospital Sept. 15, 1890. complained of shortness of breath, swelling of feet and great swelling of abdomen. The spleen was found to be enormously enlarged, filling up the whole of the left side of the abdomen and reaching beyond the median line. Examination of the blood showed one white to four red corpuscles. There was no history of malaria. He was placed upon Fowler's solution, three minims *ter in die*, increased by one minim every other day until physiological effects appeared. In about four weeks, the proportion of white to red corpuscles was one to seventeen. He then returned home to Virginia and ceased to take medicine. He came back again Jan. 29, 1891, his blood at that time showing a proportion of one white to three red corpuscles. He was put upon arsenic, and within 19 days the leucocytosis had entirely disappeared.

May 27 he went away feeling very much better. His white corpuscles were normal and his red corpuscles numbered 4,000,000 in the cubic millimetre. His spleen, which had touched on the right Poupart's ligament, was reduced in size, extending only a hand's breadth below the costal margin. He took arsenic in increasing doses until the dose reached 12 or 13 minims *ter in die*. When physiological symptoms appeared, the dose was reduced and then started up again. He took 12 minims regularly for a matter of two months without any symptoms. Nothing was heard of the patient for 8 1-2 months. On Feb. 9th of this year he returned He said he had felt perfectly well until last Christmas. An examination revealed that his spleen was larger than ever before,

legs œdematous and a proportion of one white to every nine red corpuscles. After a week's treatment in the dispensary, he was admitted to the hospital where he has been for four weeks. During this time the red corpuscles have increased from 2,700,000 to 3,400,000 and the white have diminished so that the proportion instead of being one to nine is now one to thirty-five. He has gained ten pounds. His spleen is somewhat diminished in size; and his general condition has improved very much. His reaction to arsenic each time has been very striking.

It is in this condition with enlarged spleen, that treatment seems to do most good. Some cases are reported where there seems to have been a definite recovery.

DR. J. E. MICHAEL: Only a few years ago this case would have passed for a malarial one in the hands of the general practitioner, especially as the man comes from a malarial region. We owe a debt to Dr. Thayer for the thorough way in which he has presented the case to the Society.

DR. JAMES T. SMITH read a paper on the "The Blood in Disease."

DR. J. F. MARTINET, referring to a case mentioned by him at a previous meeting, of a woman suffering from acute mania associated with ovarian excitement, stated that the patient had been operated upon by Dr. Rohe at the State Insane Asylum. A week after the operation Dr. Rohe wrote that after she rallied from the operation her mind was perfectly clear and continued to be ever since. Previous to the operation she was one of the worst patients in the asylum. The nature of the operation, Dr. Martinet thought, was removal of the ovaries.

On motion of Dr. Michael, the following resolution was adopted: That the Clinical Society enter its protest against the proposed reduction in the appropriation for the library in the surgeon general's office at Washington, and that the President be directed to send this protest to the congressmen representing the State.

WM. T. WATSON, M. D., Secretary.
519 N. Broadway, Baltimore, Md.

AMERICAN MEDICAL ASSOCIATION.

FORTY-THIRD ANNUAL MEETING, HELD IN DETROIT, MICH., JUNE 7TH, 8TH, 9TH AND 10TH, 1892.

FIRTT DAY, TUESDAY, JUNE 7TH—GENERAL SESSION.

The forty-third annual meeting of the American Medical Association was held in the Detroit Opera House on the Campus Martius. The meeting was called to order at 11 o'clock by Dr. H. O. Walker, chairman of the committee of arrangements.

After prayer by the Rt. Rev. Thos. F. Davis, Episcopal Bishop of Michigan, a brief address of welcome was delivered by General R. A. Alger. The speaker expressed the pleasure he felt in welcoming to Detroit and the State of Michigan so distinguished a body. The people would do all in their power to make their sojourn a pleasant one, and every door was open to whoever sought admittance. If the medical guest did not see what he wanted, he had only to send for it; and if he did see what he wanted, he must help himself to it.

Dr. H. O. Walker supplemented this address by a few words of cordial welcome from the profession of the city, whose honor it was to entertain for the third time the members of the American Medical Association. He then introduced the president of the association, Dr. Henry O. Marcy, of Boston, presenting him with a handsome gavel made from the wood of the celebrated Pontiac tree, a tree which was a silent witness of the final triumph of the infant settlement of Detroit over its savage foes.

The president thanked the committee for its gift, and said that he felt a peculiar pleasure in being able to reciprocate by presenting to the Association a gavel with no less precious historic associations. It was made from a piece of the Charter Oak of Hartford, with a handle of wood from the United States frigate "Constitution."

"EVOLUTION IN MEDICINE"

was the subject of the President's annual address. The American Medical Association, he said, holds a position among the greatest medical societies of the world in many ways unlike that of any other. Born of a felt want by the members of a profession widely scattered in a comparatively new and imperfectly developed country, it struggled along in the weakness of its infancy, conquering the disadvantages of great distances, compassed by comparatively slow, tedious and expensive means of travel, he thought it was not too much to claim that it now stands as the exponent of the medical thought and progress of the profession of the United States.

Although the speaker held that the Association must have its own inherent law, its code of ethics, he believed that the differentiation between so-called schools of medicine should be made alone between ignorance and knowledge. Such differentiation means the abolition of ism and pathy, and there will be introduced in their stead, a more or less accurate interpretation of scientific law as to what constitutes the treatment of disease.

The speaker touched upon the relation of the American Medical Association to the general profession in America, and said that in the general

field of medicine, the great rank and file of the profession must continue to work, and as the representative body of this vast army of workers, the American Medical Association, without fear or favor, must continue to be its exponent.

He dwelt upon the relations the Association bore to the State societies, declaring that there was no occasion for jealousy, either between them or the other national societies of our great country; that the field was large and the work ample.

He referred briefly to the evils of intemperance, the matter being one which concerned so closely the members of our own profession, than whom none are better qualified to instruct the public upon the uses and abuses of intoxicating liquors.

As to the question of a National Board of Health, the speaker regarded it as one of great importance; that it had been urged with reason, and he trusted that it would soon be carried into effect. The work of the Department of Agriculture had given great satisfaction, and its field of usefulness was about to be extended by a bill now pending, which has for its purpose the protection of the public against the adulteration of the food products of the United States.

He spoke also of the friendly relations existing between the profession of this and the foreign countries; stating that there were present at the Berlin Congress over six hundred and fifty members from the United States, the largest number representing any nationality except Germany. The speaker then referred to the Pan-American Medical Congress, and said that in the early future the necessity will no longer exist for our advanced pupils making European pilgrimages for original research and study in foreign languages; but rather that our own great centers of learning will be selected as the Meccas of the best modern thought, where students of all nationalities shall gather for instruction.

The address was referred with the thanks of the Association to the committee on publication.

DR. GIHON reported the death of Dr. Brodie, of Detroit, Mich., Ex-President of the Association, and moved a vote of condolence to the family.

DR. BRAY, President of the Canadian Medical Association, was then introduced, and extended a cordial invitation to all members of this Association to attend the meeting of the Canadian Society, at Ottawa, September next.

The report of the Secretary was then read by Dr. Atkinson.

DR. MARSHALL. of Chicago, read the report of the committee on sections, which had been appointed to devise means for improving the work of the various sections The committee advocated that more time be given to section work, by shortening the general sessions. The report was adopted.

A long report of the committee on Secretary of Public Health was then read. After a protracted discussion the report was adopted.

Although there were several committees yet to report, it was so late that an adjournment was had, in order not to encroach upon the time allotted to the work of the sections.

In the evening a reception was tendered to the members of the Associa-

tion and their ladies at the Light Infantry Armory, by the medical profession of Detroit.

SECOND DAY, WEDNESDAY, JUNE 8TH.

The session was opened at 11 o'clock by the President.

The Secretary read a resolution offered by Dr. Houghton, of Vermont, calling for the appointment of a committee to consider the changes, if any, that it may be deemed necessary to make in the code of ethics. Adopted.

The judicial council reported that the New York State Medical Society and the Erie County Medical Society are not in affiliation with the American Medical Association, and that hence, Dr. W. W. Potter, of Buffalo, as a member of these societies, cannot be recognized as a member of this Association.

Dr. Reynolds, of Kentucky, moved to refer the report back to the council for consideration.

The president decided that the question was out of order. An appeal to this ruling was taken, but the President was sustained.

DR. C. A. L. REED, of the committee on the Pan-American Medical Congress, reported progress.

DR. VANDERVEER, of Albany, here arose to a question of personal privileges as to where he and several others of his colleagues stood, as they were also members of the New York State Medical Society and permanent members of the American Medical Association. After considerable discussion upon the matter and the introduction of several motions, a substitute was finally offered by Dr. King, of Missouri, with an amendment by Dr. Gihon, of the United States Navy, and a further amendment by Dr. Traux to the effect that the President appoint a committee of five to meet a like number from the New York State Medical Society to adjudicate upon the standing of the members who are also members of that society, to report at the next annual meeting and that until such report was made all permanent members from the State of New York now registered, retain their privileges in the Association, which was unanimously carried.

DR. JOHN B. HAMILTON then delivered his address on Surgery, the subject of which was, "The General Principles of the Surgery of the Brain and its Envelopes." The speaker reviewed the history of cerebral surgery from the earliest times down to the present. He said that although the progress in cerebral surgery had been considerable, there yet remained much to gain in this field.

On motion, the address was referred, with the thanks of the Association, to the committee on publication.

After the reading of some notices by the Secretary, Dr. Atkinson, the session was then adjourned.

THIRD DAY, THURSDAY, JUNE 9TH.

DR. GIHON presented the annual report of the Rush Monument Committee.

A resolution was passed endorsing the Association of Medical Colleges in their efforts to raise the standard of professional education.

The report of the trustees of the Journal of the American Medical Association was then presented, and after some discussion, accepted.

The committee on the Jennerial Centennial recommended that the Association devote one day during the meeting in 1896 to eulogies, papers and voluntary essays on Jenner, and the practice of vaccination.

Dr. ALFRED L. GIHON, U. S. Navy, took as his subject of the address on general medicine, "Intellectual Progress in Medicine." He urged an earnest countenance and substantial support of medical literature, both by subscription and contribution.

He said that a minimum of three full courses, in many schools four, and these consequent upon prerequisite academic or collegiate tuition, expressed in one university as six years of continuous collegiate tuition for the intending physician, is a prouder acheivement in medicine in this year, 1892, than all the addition to its pharmacopœia or all the refinements of its therapeutic theories.

The committee on nominations has selected the following candidates:

Dr. Hunter McGuire, of Richmond, Va., President.

Dr. H. O. Walker, of Detroit, first Vice-President.

Dr. H. Brown. of Kentucky, second Vice-President.

Dr. H. Janes, of Vermont, third Vice-President.

Dr. Jesse Hawes, of Greely, Col., fourth Vice-President.

Dr. R. J. Dunglison, of Philadelphia, Treasurer.

Dr. W. B. Atkinson, of Philadelphia, Secretary.

Dr. Montgomery, Assistant Secretary.

Dr. Geo. W. Webster, of Chicago, librarian.

To fill vacancies on the board of trustees: Dr. Alonzo Garcelon, of Lewiston, Maine; Dr. Leartus Connor, of Detroit; Dr. Perry H. Millard, of Minnesota, and Dr. Patterson, of Washington.

Members of the judicial council: Dr. N. S. Davis, of Chicago; Dr. John Morris, of Baltimore; Dr. H. D. Didama, of New York State; Dr. John B. Roberts, of Philadelphia; Dr. A. M. Emmert, of Iowa; Dr W. T. Briggs, of Nashville; Dr. C. W. Voorhes, of Coldwater, Mich.; Dr. W. E. B. Davis, of Rome, Ga.; Dr. A. Morgan Cartledge, of Louisville.

Milwaukee was chosen as the next place of meeting.

SECTION IN PRACTICE OF MEDICINE.

FIRST DAY, TUESDAY, JUNE 7TH.

The Relation of Bacteria—Chemical Results to Prophylaxis and Therapeutics, was the title of a paper by Dr. Robert T. Edes, of Jamaica Plain, Mass.

Immunity, by Dr. Kinsman, of Ohio.

Etiology of Specific Disease, by Dr. R. French Stone, of Indianapolis.

Recent Investigations of the Etiology of Diabetes Mellitus, by Dr. S. P. Kramer.

Hepatic Abscess, by Dr. Geo. E. Fell, of Buffalo.

Influenza, by Dr. Jno. E. Link, of Terre Haute.

A Modified Form of Continued Fever following the Epidemic Grippe, by Dr. Jno. H. Hollister, of Chicago.

SECOND DAY, WEDNESDAY, JUNE 8TH.

Positive and Negative Medication, a paper read by Dr. Bedford Brown, of Alexandria, Va.

The Relative Inter-Dependence of Organs in Health and Disease, by Dr. Herrick, of Cleveland, O.

A Case of Amœbic Dysentery, by Dr. E. P. Gerry, of Jamaica Plain, Mass.

Retained Fæces, by Dr. W. D. Christopher, of Chicago.

The Transmission and Behavior of Typhoid Poison as Observed in Country Practice, by Dr. L. N. Davis, of Farmland, Ind.

Catarrhal Gastritis, by Dr. Harold N. Mayer, of Chicago.

The Vertigo of Arterio-Sclerosis, by Dr. Archibald Church, of Chicago.

On Some Non-Valvular Heart Murmurs, by Dr. N. S. Davis, Jr., of Chicago.

The Importance of Position in Examination for Diseases of the Heart, by Dr. O. B. Campbell, of Ovid, Mich.

SECTION OF SURGERY AND ANATOMY.

FIRST DAY, TUESDAY, JUNE 7TH.

Dr. J. McFadden Gaston, of Atlanta, chairman, read a paper on Surgery of the Gall Bladder and Ducts.

Obstruction of the Cystic Duct, by Dr. W. H. Meyers, of Fort Wayne, Ind.

Peritonitis from Gall Stones, by Dr. W. E. B. Davis, of Rome, Ga.

Gunshot Wound of the Liver and Stomach—Laparotomy—Recovery. by Dr. Jas. T Jelks, of Hot Springs.

Rupture of the Liver, by Dr. Ferger, of Chicago.

Eight Cases of Œsophageal Stricture, by Dr. D. S. Campbell, of Detroit.

SECOND DAY, WEDNESDAY, JUNE 8TH.

The Late Manifestations of Appendicitis and their Treatment, by Dudley P. Allen, of Cleveland.

Desemoid Tumors of the Abdominal Walls, by N. Senn, of Chicago.

Intestinal Lesions in Abdominal and Pelvic Surgery, by Dr. Joseph Price, of Philadelphia.

The Comparative Merits of Inguinal and Lumbar Colotomy, by Dr. J. Matthews.

The Significance of a Hernial Sac, by Dr. E. H. Gregory, of St. Louis.

The Treatment of Injuries of the Abdomen not Requiring Surgical Operations, by Dr. J. Schneck, of Mt. Mormee, Ill.

Emergency Work in Abdominal Surgery, by Dr. Mordecai Price, of Philadelphia.

Bassini's Method for the Cure of Inguinal Hernia applied to a Case Complicated by Undescended Testicle. by Dr. Samuel E. Millikin, of New York.

Hernia, Operable and Inoperable. by Dr. Thos. H. Manley, of New York.

A Few Points on the Management of Strangulated Hernia, by Dr. W. B. Degarmo, of New York.

The Management of Gangrenous Hernia, by Dr. Joseph Ransohoff, of Cincinnati.

The following officers were elected to serve for the ensuing year:

Dr. Jas. T. Jelks, of Hot Springs, Chairman.

Dr. E. T. Tappey, of Detroit, Vice-Chairman.

Dr. Liston Montgomery, of Chicago, Secretary.

Book Reviews.

A TREATISE ON PRACTICAL ANATOMY.—For students of anatomy. By Henry C. Boenning, M. D., Lecturer on Anatomy and Surgery in the Philadelphia School of Anatomy; Demonstrator of Anatomy in the Medico-Chirurgical College; Demonstrator of Anatomy in the Philadelphia Dental College; Lecturer on Disease in the Medico-Chirurgical College, etc. A work of 482 pages, and thoroughly illustrated with 198 wood engravings. Published by F. A. Davis, Philadelphia and London.

SYNOPSIS OF HUMAN ANATOMY.—Being a complete compend of anatomy, including the anatomy of the viscera, and numerous tables. By James K. Young, M. D., Instructor in Orthopædic Surgery, and Assistant Demonstrator of Surgery in the University of Pennsylvania; Attending Orthopædic Surgeon, Out-Patients, University Hospital; Fellow of the College of Physicians, etc. A work of 393 pages, illustrated. Published by F. A. Davis, Philadelphia and London.

These two works on anatomy make good companion works for the desk of the student, or those interested in the study of anatomy. Their arrangement and style is different, but both are concise and accurate. The table of contents and general index are particularly well arranged for ready reference. The former covers rather a larger scope than the latter, which is published in the Physician's and Student's Ready Reference Series. Both books are well edited and are fully abreast of the latest teachings in anatomy.

The illustrations are particularly well selected, as we should expect from men who have been teachers long enough to fully know and appreciate the needs of students.

W. F. W.

ESSENTIALS OF MINOR SURGERY AND BANDAGING.—With an appendix on venereal diseases. Arranged in the form of questions and answers, prepared especially for students of medicine. By Edward Martin, A. M., M. D., Instructor in Operative Surgery, University of Pennsylvania; Surgeon to the Howard Hospital; Assistant Surgeon to the University Hospital; Author of "Essentials of Surgery," etc., 166

pages, illustrated. Published by W. B. Saunders, Philadelphia.

This work is published as one of "Saunders' Question Compends," series. The subjects treated are well selected, and will prove a valuable aid to the student, in acquiring a concise knowledge of the primary principles essential to a knowledge of the subject treated. W. F. W.

RAPID DILATATION OF THE UTERUS, FOR THE TREATMENT OF HEMORRHAGE.—In a paper read before the Medical Society of London, March 28, 1892, Dr. A. Routh presented the following conclusions:

1. Menorrhagia, and especially metrorrhagia, constitute an indication for dilatation.
2. This is best done by graduated bougies under an anæsthetic.
3. Pyrexia is not to be feared, if the procedure is carried out under antiseptic precautions, unless malignant disease or tubal disease is present.
4. That even with tubal disease, dilatation is not necessarily contra-indicated.
5. That dilatation should precede all other operations for the relief of hemorrhage.
6. That dilatation often suffices to effect a cure.—*Medical Press and Circular*, March 30, 1892.

EPIDIDYMITIS.—Dr. Brewer, following the younger Langlebert, has employed in the Vanderbilt clinic what he calls the dry poultice in some twenty-five or thirty cases of epididymitis of both tubercular and gonorrhœal origin. The dressing consists of a moderately thick layer of cotton wool, applied over the testicle, covered by a layer of thin rubber protective, so fashioned as to completely cover the diseased organ, and extend up onto the sound tissue, partially enclosing the sound side. This is secured by a snugly-applied bandage, and the whole held in place by a suspensory. Its results, as regards the absorption of the induration, are rapid and marked, a very considerable diminution being seen at each dressing, and the author adds that no other method of treatment has in his hands proved so satisfactory.—*Jour. Cutan. and Ven. Diseases.*

Selections and Abstracts.

APPLICATION OF FORCEPS.

Dr. Henry D. Fry urges, as the only rational method, the application of the forceps to the sides of the head of the child without reference to its position in the pelvis. He refers to a former paper in which it was stated that fifty-one per cent. of prominent obstetricians followed this rule, while thirty-five per cent. applied the blades in transverse diameter of the mother's pelvis without reference to the position of the head, and eleven per cent. observed no rule and followed either method. He admits that had the great body of the profession been consulted, the majority would be found to apply the forceps according to the German method, and also that in some cases it may be and is impossible to do otherwise. Certainly the difficulties of application are increased when the first method is chosen, and it would be better for a beginner to resort to the second until some facility is acquired.

In France it is the practice to apply the forceps to the sides of the head even when transverse at the brim, and the ideal method of extraction is to apply the instruments in such a manner that during traction the fætal head is free to execute all the movements that would occur were the labor normal. To accomplish this it is necessary:

1. To grasp the sides of the head with the blades.
2. To make traction in the axis of the pelvic canal.
3. To secure mobility of the head during its passage, by the use of Tarnier forceps. The Hodge style of forceps should not be used when their application is made without reference to the child's head, and the Simpson style (Elliot) should not be used when their application is to be made to the sides of the head.

Dr. Fry's conclusions are:

1. Anæsthetize the patient and place her in proper position—buttocks well over the edge of the bed, and each limb supported by an assistant.

2. Ascertain the position of the head, introducing within the vagina two or three fingers, or if necessary, the whole hand.

3. Apply the blades of a Hodge type of forceps to the sides of the head, with the concave edge directed toward the occiput If for any reason this can not be accomplished, withdraw the instrument and substitute a Simpson (or Elliot) passing the blades to the side of the pelvis. While making traction with this method, watch for anterior rotation of the occiput, and encourage it in some cases by re-applying the blades to better advantage.

4. Make every effort to secure antiseptic condition during the operation. The fingers, hands and forearms of the operator, the external genitalia and vagina of the patient, the instruments and the hands of the assistants, should be clean and aseptic.—*Am. Jour. Obst.*

THE DISINFECTION AND STERILIZATION OF SURGICAL INSTRUMENTS.

According to Maljean, the best method of destroying pyogenic and infecting germs, whose resistance is increased when enveloped in a dried albuminoid, as blood or pus, is to boil all metallic instruments for twenty minutes in a solution of sodium carbonate, 1 per cent. being as efficient as a stronger solution, as it acts not as a germicide but as a dissolvent of the dried albuminoids, and allows the heat to act upon the spores. The cleaning of the instruments with soap and brush is not to be discontinued, but they are to be cleaned before being boiled; and as an efficient method of preventing the drying upon instruments, of pus and blood, he advises the placing of them, immediately after use, in a warm solution of soda that has been previously boiled for ten minutes. For instruments not entirely metallic, as knives, he advises the dipping of the blades in a boiling 5-per-cent. carbolic solution for five minutes, the whole instrument to be placed in a cold solution for fifteen minutes. He found that the spores of vibrio septicæmiæ and tetanus bacillus, when covered by dried albuminoids, were unaffected by remaining in a

5-per-cent. solution of carbolic acid for five days, and that at the end of four days they were living in a neutral 1:1000 sublimate solution, and concludes that there is no practical antiseptic capable of destroying germs in a sufficiently short time without the addition of heat.

[It may fairly be said that this method of boiling in soda solution is that preferred and employed by the great majority of surgeons at the present day, because of its convenience and certainty of action. If, however, for any reason it is not possible to employ it, immersion of the instruments for twenty minutes in a 1:20 carbolic solution, or for a much shorter time in a 1:1000 sublimate solution, will render them aseptic in the great majority of cases.]—*Amer. Journ. Med. Science.*

TREATMENT OF DYSENTERY.—Drs. Lardier and Pernet (Semaine Medicale) recommend the following treatment of dysentery—one which they have employed with the greatest success in the recent epidemic at Rambersvillers, Voges:

It is based on intestinal antisepsis, either by means of salol, or better still, iodoform. The former is prescribed in the following formula:

Salol, gr. xlv, (3.0 grammes.)
Tulu tincture, fl. dr. iiss, (10.0 grammes.)
Quince Syrup, fl. dr. vi, (30.0 grammes.)
Opium extract, gr. iss, (0.1 gramme.)
Mucilage acacia, oz. iv, (150.0 grammes.)

Tablespoonful hourly.

This medication is reported to act in a very favorable manner on the morbid process. However, the medicament which was found to have truly remarkable effects in dysentery, is iodoform, in the daily dose of 30 to 40 centigrammes, (4 1-2-6 grains.) The following formula is given:

Iodoform, gr. xv, (1.0 gramme.)
Powdered opium, gr. ix, (0.6 gramme.)

For 20 wafers—5 or 6 during the day, at equal intervals.

These wafers soon produced marked relief in the author's cases.

The incessant and extremely violent tenesmal pains were calmed by boric acid enemas; but the best means of combating them was found to be the use of suppositories of the following composition:

Cocaine hydrochlorate, gr. vi, (0.4 gramme.)
Powdered opium, gr. ix, (0.6 gramme.)
Cacao butter, dr. ii, (8.0 grammes.)
Divide into 4 suppositories, one morning and evening.

Under the influence of the cocaine, the griping disappeared as if by charm, the diarrhœa ceased, and the patients obtained a refreshing sleep of several hours' duration.

Besides the use of the medicaments mentioned, it is advised not to neglect washing out the intestines several times daily, with some antiseptic fluid—such as a concentrated solution of boric acid, or a 1:5000 solution of corrosive sublimate.—*The Med. Age.*

DOES ETHER ASSIST DIGESTION?—The effect of ether on digestive processes in healthy subjects, has been recently investigated by Dr. Gurieff, who gave thirty drops of sulphuric ether to six healthy persons during dinner, which consisted of about half a pint of soup, four ounces of meat, and six ounces of bread. It was found that the ether had the effect of stimulating the action of the gastric glands, increasing the free hydrochloric acid in the gastric juice and causing the peristaltic movements of the stomach, together with its power of absorption to increase thus; on the whole, exercising a favorable effect upon the gastric digestion. The same result was obtained when the ether was administered by means of hypodermic injections. It would appear, therefore, that the effects must be ascribed to a general, rather than to any merely local action on the mucous membrane of the stomach.

Dr. Gurieff is disposed to think that there is a stimulation of the cephalic centers. This view is partly based on the observations of other Russian observers—Bekhtereff and Miloslevski and Pavloff and Shumova-Simanovskaya—on the dependence of the gastric functions upon the central nervous system.—*Lancet.*

Editorial.

THE AMERICAN MEDICAL ASSOCIATION.

The forty-third annual meeting of the American Medical Association was held at Detroit, Mich., on June 7, 8, 9, and 10. The veteran founder, Dr. N. S. Davis, of Chicago, was present, among others. He is now seventy-five years old but a very active man still to be the father of the American Medical Association. There were four Associations of medical men in Detroit, within less than two weeks, and Dr. Davis was conspicuous for his influence in all of them. The meeting that was first held was that of the American Academy of Medicine, which recommended a classical collegiate education, preparatory to the study of medicine. Immediately after the American Medical Association meeting, was that of the medical colleges. All this seems to point to more interest in the education of medical students.

Dr. Davis, as chairman of the judicial committee, brought in a report that Dr. W. W. Potter, who is late president of the Medical Society of the State of New York, could not be recognized as a member and officer of the American Medical Association. The point was made by Dr. Davis and sustained by the Association, that the decision of the judicial committee was final. A motion was adopted, however, to revise the code of ethics. It is possible that this may result in a change of the time-honored position of the American Medical Association in regard to consultations with homœopathic physicians, but it is not probable. At any rate, the present meeting of the Association has taken strong ground against the new code men, and it remains to be seen whether the next meeting will make any radical changes in the Association's policy. There were several prominent New York physicians who had been invited by officers of the Association to read papers. They were anxious to know upon what footing they stood. This was a stage of momentous importance to the Association, and the

President, Dr. H. O. Marcy, and others, are to be congratulated upon the tact displayed in dealing with this question.

Another somewhat sensational episode in the recent meeting, was a hearty denunciation of the Keely cure for inebriety.

The sections were largely attended, and all reports point to renewed interest in the work of the sections. There is consequently no danger that the Association will for the present be supplanted by the special societies that are springing up throughout the United States. There is a work of united effort to be done by the Association that cannot be done by any other society, while there is also a sphere for all.

The next meeting of the Association will be at Milwaukee, Wisconsin. This will be near enough to Chicago to enable the members of the Association to attend the World's Fair at Chicago, and to profit by the reduced rates, and yet during the meeting, the members may be sufficiently isolated for efficient work of a scientific nature.

The officers that will have charge of the Association at Milwaukee, are as follows: Dr. Hunter McGuire, President; Drs. H. O. Walker, H. Brown, H. Janes, Jesse Hawes, Vice-Presidents; Dr. R. J. Dunglison, Treasurer; Dr. W. B. Atkinson, Secretary; Dr. Montgomery, Assistant-Secretary; Dr. George W. Webster, Librarian.

Among the men from the South in attendance upon the Association at Detroit were Drs. J. McFadden Gaston, Floyd W. McRae and W. E. B. Davis, of Georgia; Hunter McGuire, Landon B. Edwards, Hugh M. Taylor, of Virginia; A. N. Talley, of South Carolina; W. H. Wathen, of Kentucky; W. T. Briggs, of Tennessee, and Jerome Cochrane, of Alabama.

Dr. J. McF. Gaston is to be congratulated on the good attendance and high standard of the Surgical Section over which he presided. Forty papers were read by such men as Gaston, Marcy, Senn, Wyeth, Ransohoff, etc. He is on the National Pan-American Medical Committee, while Dr. F. W. McRae is one of the auxiliary committeemen in Georgia. Dr. W. E. B. Davis, of Rome, Ga., was one of the vice-presidents of the late meeting, and read a paper in the Section of Surgery and Anatomy on "Peritonitis from Gall-Stones." He is also on the judicial committee for the next year.

The Medical Editors' Association had a meeting in Detroit, and also a banquet, both of which were greatly enjoyed.

The *International Journal of Surgery* has an admirable report of the Surgical Section, and of the papers on Gall Bladder Surgery by Drs. Gaston, Myers, and Davis. It is signed by A. D. Among other things we find the following paragraph:

"Discussion on these three papers was then opened by Dr. A. Vander Veer, of Albany, N. Y., who congratulated Dr. Gaston on the importance and value of his work in the surgery of the gall bladder, and on the proud position he occupied both here and abroad. In the treatment of gall-stones in general he was in favor of first trying medical treatment, such as olive oil, etc., but when that failed, then surgical treatment was necessary."

We also quote from the editorial in the same journal:

"The meetings of the Section on Surgery were well attended, and the proceedings were ably conducted under the efficient management of Dr. Gaston, the Chairman. A large number of valuable papers were presented, but time did not permit of sufficient discussion to bring out the salient points of the papers read. This was a source of regret to many of the members who were anxious to discuss them. As Dr. Gaston justly remarked, a full discussion is frequently of greater importance than the paper which has brought it out.

"The appointment of Dr. Hunter McGuire, of Richmond, as President of the Association for 1893, was received with general satisfaction, and is a graceful compliment to one of the foremost surgeons of this country."

A REPLY.

In this same issue, we publish the suggestions of a brother practitioner in regard to an editorial of ours on a "Growing Evil that should be Remedied." The doctor seems to be thoroughly in accord with our views, as to the prevalence of the evil; but with the ideas of procrastination from which our profession has always suffered, simply offers palliative remedies where heroic ones should be used, or, as he says,

use diplomacy and strategy, and by these subtifuges try to accomplish what only a straight out fight will.

There has never been a suggestion of reform in medicine that has not met with bitter resistance from both within and without the ranks of the medical profession; nor do the writer's suggestions tend to correct the evil, except from a monetary stand; that of causing the patient to return at stated times, by giving him a placebo that is of no benefit—this course, we think reflects upon the dignity of the profession.

It is not by a vacillating course of this kind that we can inspire confidence and respect in the minds of the laity, but by taking a firm stand when we are right, and by maintaining it in the face of all obstacles.

We do not doubt the American habit of ideal liberty, but believe that their sense of justice is just as great. That the question is after all, a matter of education; and that whenever it is presented to them properly, and they recognize that it is for their benefit, and not ours, we will gain their hearty co-operation in executing them. W. F. W.

DEATH OF DR. L. P. KENNEDY.

Dr. L. P. Kennedy, who had been quite ill for several months with typhoid fever, died at his former home in Due West, S C., early in June. Dr. Kennedy was a graduate of Erskine College, South Carolina. He then spent one year at the Johns Hopkins University. He received his medical education from the Medical Department of the University of the City of New York, class of 1887.

After graduating, he accepted a position in the hospitals on Blackwell's Island for six months, and then spent nine months in Charity Hospital, Brooklyn.

Of him, Rev. W. M. Greer, D. D., President of Erskine College, once wrote: "He is a pleasant speaker, has a clear, musical voice, and while not an orator, has the capacity for strong, clear-cut, compact speech."

As assistant to the chair of obstetrics and diseases of women in the Atlanta Medical College, as one of the editors and proprietors of the *Atlanta Medical and Surgical Journal* and as a practitioner, he took the highest rank.

One of the editors of the RECORD, Dr. J. McFadden Gaston, has been absent during the month of June, first at Detroit in attendance upon the American Medical Association, and then at Philadelphia, actively studying the new methods of surgery. Dr. Gaston has been royally entertained at the homes of Drs. John H. Packard, John Ashhurst, Jr., J. H. Musser, and others, and has also been interested in the operations of these distinguished surgeons, as well as those of Drs. E. E. Montgomery, Joseph and Mordecai Price, Ernest Laplace, and Wharton. Dr. J. B. Roberts has had some very important cases to show Dr. Gaston, one of which was the removal of the spinous processes and arches of the seventh, eighth, and ninth dorsal vertebræ. We hope to have a letter from Dr. Gaston about his recent stay in the City of Brotherly Love.

The laying of the corner stone of the new building of the So thern Medical College took place with imposing ceremonies on the 28th of June. Dr. T. S. Powell, president of the board of trustees, and founder of the college, was the orator of the occasion. The new building will be ready for occupancy at the usual time for opening in October. It will accomodate over three hundred students in the amphitheatre, when it shall have been completed. The Southern Medical College is to be immediately in front of the Grady Hospital, and will derive great clinical advantage therefrom.

It is our pleasure to note the advent of a new-comer into medical journalism, the *Charlotte Medical Journal*, which is published in Charlotte, N. C., by Drs. E. C. Register and J. C. Montgomery. The first issue shows with what careful precision it has been edited, and its appearance is altogether quite attractive. We predict for it a bright career.

Dr. Henry M. Whelpley was married to Miss Laura Eugenie Spannagel, on June 29th, in St. Louis. Dr. and Mrs. Whelpley will be at home after August 15, 2342 Albion Place, St. Louis, Mo.

Dr. Geo. T. Brown, of Atlanta, is now in New York, at the Post-Graduate Medical School, pursuing a special course in the eye, ear and throat.

Special Notes.

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A NEW PREPARATION OF IRON, A SPECIFIC FOR ANÆMIA.—Reynold W. Wilcox, M. A., M. D., professor of Clinical Medicine in the New York Post Graduate School and Hospital, read a scholarly paper entitled, "Anæmia, its Treatment with a New Preparation of Iron," before the section in General Medicine of the New York Academy of Medicine, April 19, 1892, which was published in the *New York Medical Journal*, May 7, 1892.

The author reports the clinical history of twelve cases of anæmia which he has treated with the most gratifying success by Weld's Syrup of Chloride of Iron [Parke, Davis & Co.'s]

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By *Prof. O. S. Armstrong*, Detroit, Mich.

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Dyspepsinæ (Morse), scruple ii.
M. et. ft. chart. No. xii
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CONGENITAL HERNIA BEFORE THE OPERATION.

THE

Southern Medical Record.

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. XXII. ATLANTA, GA., AUGUST, 1892. No. 8

Original Articles.

THE RADICAL CURE OF HERNIA, PARTICULARLY WITH CHILDREN.

BY DR. G. FELIZET, SURGEON TO TENON HOSPITAL, PARIS, FRANCE.

Translated by THOS. H. MANLEY, A. M., M. D., Visiting Surgeon to Harlem Hospital, New York.

USE AND INDICATIONS FOR THE TRUSS.

For a surgical operation for hernia to merit the designation "radical cure," it will not suffice that the communication with the peritoneum is interrupted by ligation of the sac as high as possible, but the local conditions favoring its reproduction must be dissipated or removed before we are able to declare the result as a radical cure—*a hernia which does not exist and which cannot return.*

The sac in acquired hernia (we shall soon refer to congenital hernia) is the result of a slipping rather than to the distension of the peritoneum. This sliding of the peritoneum operates in the way of protrusion when favored by a weak point.

This weak point manifests its defect as in the disproportion between abdominal effort and the resistance of the abdominal

wall. The sac is the effect, the abdominal effort the occasion, and feeble point the cause of the production of the hernia.

To attack the sac only, is to expose the hernia to a speedy return.

It is to this weak point, then, that the surgeon must direct his efforts; to obliterate it and transform it, so that after operation it will be particularly solid and resistant. This result is within our power to obtain. Numerous cases of radical and definite cure of hernia may be seen to-day; and they would be more numerous, if operations were more frequently practiced under conditions favorable to rapidity of execution and final success.

In the surgery of infants, an operation long and tedious is always grave. Chloroform, shock and loss of blood are without doubt the elements of failure, rather than any act of the surgeon. But we cannot, nevertheless, reject an operation from this consideration alone, which in infants has given, and will give, brilliant results; more stable than in adults, in whom, in a general way, it may be preferable to employ the truss (bandage).

It is true that, as between an operation, uncertain in its results if any detail in treatment is neglected or fails, and which may be perilous and difficult in performance, easy and simple means of treatment are to be preferred, and hence, often the truss may be efficacious; at any rate, it is always free from danger, which may entail serious responsibility or occasion alarming symptoms, and one will usually prefer it.

It need not be repeated that the truss will cure the great majority of hernias in children; but it will not cure all, and it is for these *only* which the operation is specially recommended. The truss will cure recent, reducible hernias, when they are not voluminous and the patient not advanced in years.

But it should be remembered that its role in very early infancy is limited, by reason of the difficulties which present themselves in its application to the soft, tender tissues of the infant, which will not tolerate much pressure long, before they chafe and become rooded and besmeared, rendering any

constant pressure inapplicable. For these reasons the truss must often be discarded in very early life.

The mechanism of cure in infantile hernia by the truss is simple. The intestine is retained in the abdomen; the opening which permits a passage ceases to be dilated, by repeated protrusions of the viscera, contracts; while the force which distends the abdominal walls increases with age, the relative dimensions of the ring diminish.

During this time, under the influence of pressure, the serous surfaces close about the sac, contracting reciprocally adhesions and intercept all communication with the cavity of the peritoneum in such a manner that the internal orifice is effaced, the tract reduced, the neck obliterated, and a recurrence of the hernia impossible.

The truss will sometimes overcome irreducible hernia; but the mechanism here is less simple and the results more doubtful. The pressure of the bulb will reduce, little by little, the intestine; crowding it upward and forcing it into the abdominal cavity, where it will be supported and retained with time, the adhesions between the intestine and the sac gradually giving away, provided they are not ancient, and have not acquired a tough, fibrous character. From time to time, in the treatment of this variety of hernia, the form and direction of the pilot must be changed, in order to follow and retain the receding bowel.

It is in these cases in which we see the best possible results in the hands of the prudent surgeon, who will not permit of any interference in the way of operation, until the truss has been patiently and carefully applied for a considerable period of time.

It is in this class of cases, too, in which when the truss has been long applied, no benefit will be derived; indeed, its continued application becomes dangerous, through the condition it has brought about in the hernia itself or in the patient. Not infrequently the truss will utterly fail to retain the hernia, and we will observe, instead of closing the tract through which the intestine escaped, it will widen and displace it. It is, under these circumstances, powerless to retain

the protrusion, but powerful in the way of inducing strangulation, which it cannot obviate, but rather complicates.

In these cases, frequently, the pressure which is exercised on the cord leads to various affections—as pain and neuralgia of the cord, varicosity of the spermatic veins, hydrocele and orchitis.

A truss must be so constructed as to particularly fulfill two requirements: 1st—It must retain the hernia. 2d—It should be worn with comfort. A truss must supply these two factors or else be rejected altogether; for, as a rule, one should never wear a truss which improperly controls the protrusions or occasions suffering. We encounter hernias in which but one of these two difficulties obtain; and it is dependent rather on the consistence and shape of the pad, than on the peculiarity of the hernia itself. I am convinced that the double truss is the most valuable of all.

It would take too long here to describe, in detail, the principle on which the double truss acts when its *point d' oppin* is transferred partly from immediately over the internal ring to the entire circumference of the pelvis, which secures stability to the apparatus, and permits all movements and attitudes of the body. Besides, the frequent appearance of a hernia on the left side after the right side was cured, has for a long time led to the employment of the double truss as frequently in infants and children as in adults.

Although it is demonstrable and apparent when a truss is properly applied and it fails to serve any useful purpose, we must yet hope, for this in itself is not a justification for an immediate operation.

When we are assured it is free from undue pressure, no accident need be feared, and we may safely wait. We should always delay in certain cases of undescended testis (cryptorchidies), when the hernia is well advanced and the testicle is in the ring, restrained by the peritoneum and sac of the intestine. In this condition, neither truss nor operation—wait! Wait until the migration of the testicle and the full formation of the hernia, when we may proceed with mild, conservative methods, or by using the scalpel, according to indications presented. One should not delay, on the contrary, if the hernia

is preceded or accompanied by the testicle; as, under the circumstances, it is certain to be the seat of accident, violent pains or strangulation itself. These are the conditions which often lead to strangulation, and the radical cure then is more than a complimentary and final; it is a kelotomy of urgence and necessity for the liberation or sacrifice of the ectopic testes.

The following was a case of the class under consideration: The patient, Alfred Legras, 14 years old, who was admitted with an intra-parietal ectopic testis with a hernia. He presented grave symptoms from a strangulated hernia and compression of the testicle. I performed an operation for his relief on the 25th of November, 1885, assisted by my *internes*, M. Breton *et* Marie Wilboutcheartch. A sac was discovered in which was found the strangulated bowel and a testis of normal size, which was easily drawn downward and maintained, thanks to the suture of the ring. The sac was not ligated. The youngster left the hospital on the 12th of January, 1886; but he was retained 15 days longer than usual on account of the nature of the operation. On the 20th of July, 1890, we found the testis well down externally and the inner aperture of the canal open. He now had no more pain in the testis nor threatening of the rupture's return; hence, the truss was entirely dispensed with.

If a descending testis contracts adhesions with the intestine, we should operate. In cases in which the testis has imperfectly descended, attended with no protrusion, by the time puberty is reached a practical cure may be effected by the normal lodgment of the testis and the gradual, but perfect, closure of the canal.

We had to do an immediate operation once, in a case in which the phenomena of compression of the testis and strangulation of intestine were well pronounced.

As a general rule, we advise delay in the ordinary hernia. A truss should be applied which is adaptable to the varying demands of the case, and worn until a cure is effected, or it would become a source of great discomfort. To determine how long it must be worn may be a matter of months or years. This is why, as a general rule, the radical cure of hernia by incision should not be recommended until after the fourth

year, and if at this time, or even later, we are rewarded for our pains and patience by the retention of the protrusion, very much has been accomplished, and we have nothing to regret.

The wearing of the truss, even though not attended with the best results, always, nevertheless, causes a diminution in the size of the sac, a retraction of the neck and narrowing of the rings; conditions which favor the ulterior cure by radical intervention.

We have said not to operate under four or five years of age. "Not until five years of age," says M. Berger, "should the radical operation *ever* be undertaken." This limit of age is an effective rule of surgery. But it is a rule which has exceptions. For example, when one has to do a kelotomy for strangulation, we may effect a radical cure without compromising the life of the patient. On a case of this description we have operated as early as the eleventh month, and we have read of others.

However, we may be prepared for dangers and difficulties both before and after operation, when the hernias are of enormous size or augment rapidly in volume; when they contain many coils of intestine and constitute, in fact, a sort of accessory abdomen. Regardless of age, also, we must interfere as soon as possible when it appears that the hernia is rapidly increasing in size, though the truss be constantly worn. This year we operated on an infant eight months old, who had two large inguinal hernias descending as far down as the internal condyles of the femur. The operation was successful.

The operation for the radical cure of hernia on patients ranging from eight to eleven months of age is truly a surgical curiosity. But even with these successes, it is not to be generally recommended; though it is sometimes possible to interfere with impunity at a very early age.

INDICATIONS FOR THE RADICAL CURE OF HERNIA—RULES FOR OPERATIONS.

No one can upbraid us for hesitating to make fully known the advantages of the truss in effecting cures in early infancy and adolescence. We have endeavored to impress that an

operation is not permissible or is inapplicable in every case of hernia, except those in which the truss is useless or intolerable; but we believe also that the radical cure of hernia by operation is nearly always free from dangers, if conducted according to the following indications :

1st. *Operate as rapidly as possible.*

2nd. *Have a careful regard for the nerves and vessels of the spermatic cord.*

3rd. *Carefully avoid bringing any septic matter in contact with the intestine, peritoneum or the wound.*

4th. *Be assured of complete obliteration of the intestinal canal.*

5th. *Establish a powerful septum, broad, strong and solid, at the point of depression of the internal orifice.*

After having performed operations for the radical cure on old men and adults, in an active service at Tenon Hospital, with infants and children more than twenty times for radical cure, we believe that we have devised a procedure which renders the operation short, simple, easy, harmless and definite, by a plan which is herewith described.

1st Indication—Operate as rapidly as possible.

It has been said that an operation unattended with difficulty was without value, as a radical cure must be a difficult operation; as if its ready performance was incompatible with rapid cure; as if the value of the procedure depended on something quite beyond the surgeon's art. The real difficulty lies in the varying methods and on individual, local conditions, the operation and the operator. But as a matter of fact, the result depends on the minute attention to detail and the most perfected methods.

Our work has for its object the presentation of a better *technique*, which will permit of a considerable reduction of the duration of operation. With equally satisfactory results, everyone will agree that a short operation is preferable to a prolonged and tedious one. A rapid operation has the advantage which less manipulation and division of structure implies, and the *minima* of the tissues are exposed to the irritating atmosphere. This is no indifferent advantage, when we are operating on infants or feeble subjects, incapable of endur-

ing chloroform for an hour or more. The fear of a protracted operation has certainly prevented many surgeons of great authority from attempting the radical cure in cases often the most appropriate for this line of treatment. "It is imprudent," says M. Berger, "to extend an operation longer than the time necessary to expose the sac as far up as possible. We must endeavor to diminish that shock which may lead to mortal collapse and reduce to its shortest possible period that time during which the patient is submitted to the anæsthetizing agent. A practice of three years in the hospital of Bicetre has demonstrated to me that with the aged, afflicted with strangulated hernia, a cure is accomplished when an operation is rapidly conducted, and I have been led to renounce with them absolutely tentative methods for the radical cure."

When one can perform the operation for hernia in fifteen or twenty minutes, it must be seldom that there is any contra-indications. If one can diminish an operation two-thirds the time, we can comprehend why it might be possible at one *seance* to operate on two inguinal hernias as we have done on a patient with success, in 1887, and we also recently tried the same course on an infant with two enormous inguinal hernias, the report of which we have heretofore published. Our patient was but eight months old. We had intended to wait for several days before undertaking the second operation, but we completed both at the same time, and by a good stroke of fortune he recovered.

2nd Indication—Care of the vessels and nerves of the cord.

It is only necessary to see once for one's self, by the ordinary proceedings in an operation for the radical cure of a congenital or acquired hernia, to comprehend the extreme attention which must be given in order to avoid annulling the elements of the cord, its vessels, ducts and nerves. Very often it might be more correct to say rather the divided, scattered elements of the cord of which it is constituted. The vas deferens is easily made out in the adult, thanks to its consistence, yet one may wound it, as once happened to M. Lucas Championniere, and he was obliged by an accident of this sort to castrate.

The most trying to identify are the vessels; as they are-

lodged in a movable, soft mass, they are often very difficult to distinguish, and to ligate them would be to destroy the integrity of the testes. When in search for a spurting vessel, which we cannot readily control, however, we must apply the ligature, whatever it may be. And who knows but the secluded vessel is the spermatic vessel itself? This ligature secured amidst loose tissues, who knows how many nerve filaments may be engaged? But unfortunately, the compression of these nerve filaments may lead to serious consequences, to severe pain and grave nerve troubles of that same nature, which sometimes occasions the surgeon anxiety after castrations.

We believe that we have succeeded with a plan, by which in the division of the external arteries, in the division of the subcutaneous tissues, we have had to apply no ligatures in dissecting the sac and isolating the cord, and in congenital hernias as readily as in those acquired, they were made absolutely *a blanc.*

3rd Indication—To preserve the intestine, peritoneum and incision from all contact with septic infection.

We must have this in view not only in inguinal hernia, acquired or congenital, but hernia of every description. The preservation of the elements of the cord has been, till the present, our principal pre-occupation in the conduct of the operation.

We have now arrived to the neighborhood of the sac. What we shall say here will apply to other species of hernias, to crural hernia, certainly (we have operated on three of them by this means), and umbilical hernia. However, we have not yet tried it. The surgeon divides the tissues, ligates the arteries, if necessary, and preserves the elements of the cord without having yet disturbed it.

Without having lost any blood, the sac is reached and opened. Here many eventualities are to be observed:

1st. The hernia has not descended, the sac is empty, flat and imperceptible. This is an unlucky mishap, which we not infrequently encounter, and is very embarrassing. When the hernia is old and the patient an adult, we quickly reach it, and with the finger recognize the fibrous bed in which the sac

is enclosed. With the infant the case is different; the sac is thin and fragile; it is neither recognized by its consistence nor its color. It is deeply buried, and quite lost in the adjacent tissues of the region.

There is but one rule in dealing with it—search. Search with prudence and the gentle use of the scalpel, aided by the forceps and the scissors to disassociate it from the connective tissue. Almost immediately under the point of the scalpel we see the thin, fragile layer, of a pearly pink color, so characteristic of the peritoneal investment. It is gradually stretched and a small opening made; its lips seized by the forceps and well opened.

In the third stage of the operation, it is the intestine with which we are chiefly occupied. The finger is now introduced and carried between the walls of the sac, above the ring, into the abdomen, in order to be assured that the gut has contracted no adhesions about the internal orifice. It is necessary in using the scalpel here, that caution is employed not to open the bowel, and to avoid this serious accident it is recommended after opening the sac to press the neck away from it with a small sponge, secured in a long forceps. When the pouch contains the intestine, it is not opened, and may be readily recognized by the color and consistence of its contents. No difficulty is now recognized, and with the division of the riveting tunics, the sac comes into view. The intestine reduced, it is yet pressed lightly so that the sac may be drawn downwards and out and piped in the opening with two forceps. The intestine having been completely returned, following the ordinary proceeding, the neck is pressed with a forceps moderately, a sponge applied high up and the dissection of the sac proceeded with.

If the intestine cannot be reduced, or reduced only in part, its detachment and complete liberation become a matter of difficulty and peril. If it appears that its adhesions are very firm and intimate, we act wisest by leaving it undisturbed. No danger is greater in attempting to separate the bowel, in certain cases, than is likely to follow by leaving it in position. If we remember that this dissection is accomplished on an irregular surface, changing and movable, without any firm

support, we way appreciate the difficulties which attend it and which cannot be wholly avoided. It is in this class of cases we often prefer to simply open the sac and partly liberate it, rather than take chances or proceed in a laborious manner to completely detach it.

In these cases in which both sac and intestine are agglutinated, though dissection is possible, so much mutilation has been borne by the peritoneum that it is practically sacrificed, as the sac is bruised and torn, and is incapable often to serve as a guide for the final exclusion of the internal orifice of the ring.

Finally, when we meet with a congenital hernia with incomplete descent of the testis, in which a coil of intestine proceeds it, it is not enough to have recognized the sac, to have dissected it, to have re-entered the coil of herniated intestine; we must, besides, provide against the testis following it, because the testicle in rising upwards would be by its presence a permanent obstacle to the occlusion of the track, and there would remain a constant danger of strangulation at the internal orifice. It is then, with a view of securing perfectly a definite re-integration of the intestine above, and of permanently maintaining the testicle below, that we proceed to the fourth indication.

(*To be continued.*)

DIPHTHERIA.*

BY A. BOWEN, M. D., NEBRASKA CITY, NEB.

Eleven years since, at the request of this Society, I addressed you upon this same subject, and if to-day at the request of your chairman of Committee on Practice of Medicine, I come before you and say that I have no new suggestions to make on treatment, you may think that I lack the spirit of progressiveness; and that the light which science sheds over all things, had not visited my eyes.

The revelations of nature are old and the power of drugs remain the same to us that they did to our fathers.

*Read before the Nebraska State Medical Society at Omaha, May, 1892.

The same treatment which I used to abort tonsillitis forty years since, in the Catskill mountains, is all-sufficient, and has always been, in extinguishing diphtheria. If the patients are seen early and treated from the first with *overbearing and persistent earnestness*, nothing less than this will answer, and this always will. I am not blind to the fact that different epidemics of diphtheria, like different epidemics of small-pox and scarlatina, possess different degrees of malignity, and will claim their victims. But I do know, that all of you who are *terribly in earnest* can limit the mortality to less than five per cent. I do know (*I do not conjecture*) that German children are more obnoxious to the disease than American children. Probably this is due to their different mode of living.

Three years since, I was called to two families of Germans eighteen miles from my residence. Seven members, who were children, in one family, and four in the other. They had contracted the disease from the contagion of a corpse at a funeral. One in each family had the disease for several days before I was called. I said to the parents that those two would die. Knowing that my word was law in those two houses, I unhesitatingly commenced the same course of treatment through the day, among the sick and the well. Among them was a baby who nursed a bottle. Their throats were earnestly swabbed every two hours during the day, and the sick during the day and the night.

As fast as they came down with the disease, I swabbed during the night as well as during the day. Every child had the disease, and every child except the one in each family, recovered. These two were the last children I lost of diphtheria. When the epidemic commenced last November, the chairman of the Board of Education wrote to all the medical men in town, requesting their opinion of the necessity of closing the public schools. All but one dissuaded them from closing. It was the mildest and the widest spread epidemic of diphtheria I ever saw. Still, there is enough diphtheria in every case to kill, if neglected. I always grow poor in flesh when treating diphtheria. As a gargle for children who are exposed to contagion or infection, a 4 per cent. solution of carbolic acid, thoroughly mixed with cold strained tea,

either gargled, or better yet, mopped deep in the throat, every four hours, or if the disease has invaded the nostrils or nares, or threatens to, the same wash sent through a two or three drachm glass syringe, with somewhat forcible jet, a small cork being fitted to the nostrils of the child with an aperture through the cork to fit the nozzle of the syringe; and the child always held perpendicular. If the disease has invaded the throat, as it usually has then, more earnest means must be used there.

Of twelve parts by measure:

One part must be carbolic acid; three parts sulphurous acid; four parts muriatic tincture iron; four parts glycerine.

The throat to be swabbed or mopped deep with this solution every two, three or four hours. They must eat and they must sleep, and here comes in the tact and discretion of a good nurse and all you possess of these qualities, you will find available. Intubation is a more respectable apology than laryngotomy, but the latter is a merely bloody excuse for early neglect. *Arrest* the disease at its earliest moment, and save the patient from its terrible alternatives, asphyxia or septicæmia.

If your patient resists you, swathe him or her tightly from the chin to the toes, and get the mouth open by the help of a soft pine wedge. They will not resist you if their throats have been properly educated.

As to the cause of diphtheria, we do not possess much more accurate information than of the cause of small-pox, or scarlatina, or the epizootic. We hear that the latter disease has struck our Eastern coast, and we know that in about so many days it will show itself in our stables, though the wind may blow a gale from the west all the intervening time.

"Diphtheria is surely a pestilence that walketh in darkness." Belknap says, in his history of New Hampshire, that a visitation of what was probably, from the description, diphtheria, first visited our country in 1735. Of the first forty who were attacked, none recovered. In the parish of Hampton Falls, twenty-seven persons died in five families, and one-sixth of the population died in thirteen months, and twenty families buried all their children. We may have reason to

fear (for we have seen a similar error committed in our day) that some physicians may have depleted for the wretched fever which accompanies the disease, forgetting that it is adynamic in its character.

Belknap says of the Boston visitation at this period: "The physicians having, by desire of the select men, held a consultation, published their opinion that it proceeded entirely from *some occult quality in the air.*" Can their successors of the fourth generation give a more definite answer with assurance? And at what earlier day did an American town institute *scientific inquiries* as the basis of sanitary measures?

I cannot look upon diphtheria even in our present ignorance of its prime cause, as one of the *opprobria medicorum*, but as a disease to be met earnestly, and in a hopeful mood.

TURPENTINE IN TYPHOID.

BY J. J. WALLER, M. D., OLIVER SPRINGS, TENN.

It is an extensive practice and almost an universal rule to treat typhoid, so far as medication is concerned, on the antiseptic and antipyretic plan; and in regard to the antiseptic used, turpentine seems to stand at the head of the list. Many others, of course, have their advocates. The condition of affairs and array of symptoms in a regular case of typhoid seems to be peculiarly met by the physiological action of turpentine.

It is hardly probable that turpentine passes down the alimentary tract, as is generally supposed, and acts locally on the inflamed Peyer's patches, for it is well known that the stimulating effect of the turpentine is felt and realized long before the agent has time to travel several feet down the intestine and reach the seat of the lesions. It is probable, and even likely, that a small portion of it may do so, but the amount must necessarily be so small that the good effect from the turpentine is brought about in a different way.

I do not believe that typhoid should be considered to dwell alone in Peyer's patches; the nervous system is prostrated, especially the sympathetic. The secretions, and they are

governed by the sympathetic, do not continue with the usual vigor. The mouth is dry, stomach often nauseated and the bowels tympanitic and full of gas—all we imagine due to the lack of proper secretion.

Turpentine is a good stimulant to the sympathetic, for under its use the mouth becomes moist and the tympanites relieved. If the secretions of the intestines, both mucous and serous, be aroused by turpentine (which we assume to be a fact), the gentle vermicular action is facilitated, and as a result the gases are either not generated, or else they are expelled or absorbed, and the pliant coat of the bowel is not so subject to extensive ulceration and inflammation.

The proper amount of turpentine in any case has to be determined by the effect it has in that particular case, for the state of the secretions is the guide to the amount used. It is well enough to bear in mind that turpentine sometimes deals harshly with the kidneys and brain, and in some instances it seems to be poisonous to the whole system, and cannot be borne at all. When such is the case, its bad effects may be overcome by combining it with other suitable remedies. For example, the following will illustrate:

R Spirits Turpentine .. ..dr. iss
Po. Acaciæ..... .....
Sach. Albæ.....aa dr. ii
Tr. Opii Camph.....
Listerine.....
Aq. Camphoræ.....
Aq. Cinnamomi.....aa oz. i
M. Ft. Emulsion.

The opium, benzoic acid, ol. anise and camphor protect the kidneys, and at the same time the opium and camphor support and quiet the brain and nervous system. The listerine keeps the stomach in good condition, while the eucalypus it contains acts as a febrifuge tonic.

With turpentine as the chief, and the other named remedies to corroborate and correct, I find to be good medication in typhoid.

REPORT OF A CASE.

BY R. R. KIME, M. D., ATLANTA, GA.,
Lecturer on Gynecology Southern Medical College.

Mrs. R., age 34, widow four years. Had two children, youngest 8 years old. No miscarriages. First flow at fourteen years of age, regular but scant, and for last two years very little, not lasting but one day. Severe pains at flow, before and after; much worse last two or three years; leucorrhœa. No special difficulty at confinements. "Rigors of pain," as she expressed it, at flows and often between times, especially when food did not digest well. Has taken a great deal of soda for "sour stomach;" also calcined magnesia. Pain principally in lower part of bowels, mostly on right side. Tenderness constant; worse at times and most marked on right side. Had rupture on same side at 12 years of age, for which she wore a truss eighteen months, and recovered. Bowels always constipated except within last twelve months. Dates trouble as commencing four or five years back; worse since an attack of la grippe in January, 1891. Confined to bed since last December, not able to do any work for last eight or ten months. Been under treatment of different physicians for the last two or three years.

Examination revealed lacerated cervix, uterus enlarged. Right ovary enlarged and prolapsed, but on account of excessive tenderness and pelvic deposits, could not map out tubes and left ovary.

Under local vaginal applications of iodine, boro-glyceride and glycerine tampons, with hot water vaginal douches, the deposits seemed to clear up to some extent, but the tenderness prevented a satisfactory examination without anæsthetic.

From history of case, physical condition, almost constant elevation of temperature for some months, and amount of suffering, an abdominal section was decided upon by Dr. J. C. Avary and myself, without further examination.

A severe attack, May 3d, of intercostal neuralgia, followed by sick stomach and accumulation of gas in bowels, caused postponing of operation to May 10th. Evening before operation

temperature 100 degs. Had not been clear of fever at any time since arrival, April 28th.

Physicians present at operation: Drs. Avary, Elkin, Childs and C. Evans Johnson.

The right tube and ovary were brought up and removed with very little difficulty. Left ovary could not be reached until incision was enlarged to admit all the fingers of one hand. In separating and bringing it up, encountered a hard nodule about size of normal ovary, which, on inspection, seemed to be a deposit in wall of descending colon, and by the advice of Drs. Elkin and Avary was dropped back and let alone.

Abdominal incision closed with silk worm gut. Within eighteen hours after operation, 1-6 and 1-10 grains hypodermics of morphia were used to relieve intense pain. Bowels moved second day by enemata of salts, quinine and glycerine, as she could retain nothing by stomach. Highest temperature three days after operation, 101 1-2 degs., due to getting out of humor, bowels not moving sufficiently and taking some nourishment that did not agree with her, after which diet was limited and bowels were kept moving each day by enemata and calomel triturates, which acted promptly in relieving pain and reducing temperature.

Removed stitches on 9th day. Union perfect, not a drop of pus. Sat up on the 15th day; returned home on the 19th day—a distance of 100 miles—as she said, feeling better than she had in two years. Suffered very little pain returning home.

Remarks. Very little changes in tubes and left ovary. Right ovary contained a cyst holding one ounce or more of bloody serum; examined microscopically by Dr Childs. We decided it to be an endothelioma of the corpus luteum changing to a hematoma.

The literature on this condition of the ovary seems to be very scarce, while I am inclined to believe that diseased conditions of the corpus luteum are of no uncommon occurrence.

The most extensive article I know of on this subject is the one by Francis Foerster, in *Amer. Jour. of Obst. and Diseases of Women*, May, 1892. He states that Dr. M. D. Jones designates these conditions of the corpus luteum as "endotheli-

oma changing to angioma and hematoma, and gyroma as a prestage of endothelioma." Foerster states, "It indeed appears that what was previously called a corpus luteum is invariably an endothelioma. This formation in some instances is pathological; as such it is always morbid when changes take place toward the formation of hematoma. The physiological corpus luteum, or endothelioma of pregnancy represents the only exception." Dr. Foerster bases his conclusions on an analysis, clinical and microscopical, of twenty-five cases of ovaries removed by abdominal section.

Pozzi, in his late work, devotes but one page to cysts of the corpus luteum, and claims that Rokitansky was the first to describe this form of cyst, and believed that the corpus luteum of pregnancy only could be transformed into a cyst.

Later investigations have demonstrated that cysts gyroma, endothelioma and hematoma may develop in the corpus luteum of menstruation. None of them attain a very large size, but are often very painful, and produce general nervous manifestations. It will be a question of the future to decide the necessity of the removal of the entire ovary in these conditions, or whether the diseased structure may simply be removed, and leave behind the healthy portion of the ovary.

It is here that the general practitioner should recognize that there are conditions of the ovary outside of pus formation and the ovarian cyst proper, that demand abdominal section and removal of the offending member for relief of patient. These diseased conditions of the corpus luteum, causing such intense suffering and invalidism, are very difficult to recognize by physical examination.

It is just such cases that the general practitioner often treats for months or years without relief—the only result often being to aggravate the condition augmenting the inflammatory condition and increasing the adhesion, thereby rendering the operation more difficult when resorted to as a last chance of relief. There is also another danger which I do not think is imaginary, and that is rupture of these cysts or hematomæ of the corpus luteum, with escape of contents, setting up a pelvic peritonitis; also, in the treatment of these cases, the physician should be cautious and not use too much

force or pressure in replacing ovary or uterus, or breaking up adhesions, for fear of rupture as above mentioned.

When a general practitioner has a case of this character, which ordinary means fail to relieve, the case should be referred to one doing special work in that line, to decide as to the advisability of operative measures.

It is an injustice to the patient to keep her a sufferer and an invalid year after year with temporizing measures, when by a comparatively safe operation, she can be restored to health and usefulness.

ITCHING IN SCARLET FEVERS is not always agreeable, but it has never been supposed to be a favorable sign, yet St Phillippe (*Rev. Mens. des Mal. de Lienf.*, February, 1890,) according to A. F. C., in *Archiv. Ped.*, in a paper presents the following conclusions:

1. Scarlatina is a disease which is often accompanied by itching.
2. This variety usually has a favorable prognosis.
3. The itching is due to the fact that the eruption is not intense, and the cutaneous lesions not very profound.

The best application for the relief of this itching, or almost any other for that matter, is the following:

R Campho-phenique..... .....oz. ss
Albolene Unguent .....oz jss
M. Sig. Apply night and morning.

Another advantage is, that in the direction of personal disinfection.

STRONTIUM LACTATE IN TÆNIA.—Laborde ("*Journal de Med. de Paris*") has had excellent results in tænia with the usual dietary care from the following:

R Strontii Lact. (Paraf-Javal).....dr. j
Aquæ .....dr. viij
Glycerini..... .....q. s.
M. S. Two teaspoonfuls every morning for five days.

This is practically the same strength as the standard solutions of Stron: Lact: (Paraf-Javal) used so largely in albuminuria.—*Medical Standard.*

Correspondence.

NEW YORK LETTER.

NEW YORK, July 19, 1892.

Pyoktanin is now largely employed by gynecologists in this city in the treatment of carcinoma of the uterus, and with very marked success In treating these cases by means of this drug, the uterus is first thoroughly curetted and packed with iodoform gauze. The gauze is removed after twenty-four hours, and a 1-300 solution of pyoktanin is then injected. Dr. Boldt, of this city, has at present thirteen cases of carcimona of the uterus under treatment by this method. In all cases radical treatment by hysterectomy was absolutely contra-indicated. The parovarium was infiltrated, and in six of the cases the vagina was involved, and in one case the disease had extended to the bladder. In only two of the thirteen cases did the disease progress, while in the others it remained stationary.

The general opinion of gynecologists in this city appears to be in favor of the use of pyoktanin in carcinoma of the uterus, as in most of the cases treated in this city the patients were greatly benefitted by its use.

The death rate has been extremely high this month, as compared with the same period last year. For the twenty-four hours ending at noon on July 12th, there were 260 deaths in this city, which was the largest number of deaths for any one day reported in over three years. This large death rate was chiefly among children, upon whom the effects of the hot weather are felt with special force.

Dr. DeGarmo, in speaking quite recently on the use of trusses for hernia in children, said that he condemned all infant trusses which are made to apply from the side of the rupture, all where the pad is placed upon a decending arm at a level lower than the pelvic spring, and all trusses padded with soft material. In making a selection of a truss, the following points should be borne in mind: First, the spring

should be so tempered that it may be readily bent to the exact shape of the child, and its pressure added to, or diminished, by increasing or removing the amount of curve which it possesses. Second, the entire truss should be impervious to moisture, that it may be frequently washed; and third, it should be durable. The more simple in design a truss is, the better it is, as a rule.

The truss should be worn for at least one year. For the cure of umbilical hernia in infants, he advises the use of a cork as a compress, so cut as to press slightly into the navel and support the surrounding parts. The corks used by druggists for wide mouthed bottles will serve this purpose exceedingly well. A thin layer of absorbent cotton is placed under this, and the whole is strapped down by a one-inch strap of Mead's rubber plaster passing two-thirds around the body. It will be sufficient to change this dressing but once a month. In infants, Dr. DeGarmo has found that the injection of Heaton's fluid helps the cure, though it rarely succeeds with adults.

At a recent clinic held by Dr. Sims, at the New York Polyclinic, a woman 23 years of age, presented with the symptoms of amenorrhœa, due to a non-development of the uterus. Speaking of the treatment of this condition, Dr. Sims said that the only plan he has found to be better than all others, was dilatation of the canal and stimulation of the uterus, and permitting the patient to wear a self-retaining stem for a considerable length of time. In this way, the uterus gradually grows in size, and menstruation appears with more or less regularity, until the courses are completely and permanently established.

Though the colleges are all closed for the summer season, the hospital clinics are still being kept up with unabated interest, and are well attended by doctors from out of town. There is always such an abundance of excellent material to be had here, that at no time of the year can there be said to be an absolute dearth of operative cases. A large and comfortable operating room has been recently erected in the Presbyterian Hospital, and the cases there are at all times worth at-

tending, as the operator takes great pains in explaining every step of the operation.

The four great hospitals of New York, viz.: the Presbyterian, New York, Roosevelt and Bellevue, are always objects of interest to the visiting doctors from out of town.

Dr. P. F. Munde, Professor of Gynecology at the New York Polyclinic, related to his class the history of a case of sufficient interest to repeat here. The patient was a married woman, 28 years of age, who was attended in her confinement by a midwife. This midwife gave the patient some medicine which produced severe uterine contractions, with the child occupying the transverse position. The visitor grew frightened and sent for a physician, who, when he came, found the head in the pelvic cavity, and delivered by the forceps. After the delivery of the child, he put his hand into the vagina and it went right into the abdominal cavity, the external os being firmly closed. Twelve hours later, Dr. Munde saw the patient, and on examination, he found an enormous rent in the posterior vaginal wall, through which his hand readily entered the abdominal cavity. He put iodoform gauze into the vagina, and placed a drainage tube in the peritoneal cavity through the rent in the vaginal wall, and waited till the next day to sew up the tear. When he again called, the temperature was 104 deg. F., and the pulse quick and small, so he did nothing. The drain was kept in a few days longer, and an offensive discharge flowed out. The vagina was irrigated gently, and the bowels moved by Rochelle salts. The rent in the posterior vaginal wall closed up spontaneously. Dr. Munde said he had seen a dozen such cases of tear of the vaginal vault, the child having escaped into the peritoneal cavity, but they all died. The point about the treatment of the case he wished to emphasize, was not to do too much.

EGGS IN RECTAL FEEDING.—Dr. A. Huber (*Le Bull. Med.*) has used eggs, to which a gramme (fifteen grains) of sea salt has been added, with success in rectal feeding, without ever observing any albuminuria. Too much salt is liable to cause profuse diarrhœa. The injection should be carried well up into the intestines, by means of a soft rubber tube.—*Ex.*

Society Notes.

CLINICAL SOCIETY OF MARYLAND.

BALTIMORE, MD., April 1, 1892.

The 265th regular meeting was called to order by the President, Dr. Robert W. Johnson.

DR. WM. S. GARDNER read a paper upon "The Mechanism of Axis Traction Forceps." A pair of forceps designed by the author were exhibited.

DR. FRANK DYER SANGER read a paper on "Death Following Supra-Pubic Aspiration of the Bladder."

The patient was seventy-five years of age, white, large, rather fleshy, full habit. Had had trouble passing his urine for some time, but never retention. For three days had suffered much pain in the region of the bladder, and could only pass a small quantity of urine at a time. Examination showed the bladder to be moderately distended, its summit about two inches below the umbilicus. A hot bath gave no relief. A number of strictures were found in the urethra, nevertheless a long curve catheter was passed as far as the prostatic urethra. Nothing could be passed further. Seven hours after the patient was first seen, aspiration was determined upon, as I felt sure the bladder would suffer if not soon relieved. A double inguinal hernia and a rather thick accumulation of fat over the pubes, decided me to insert the needle well up. Having used thorough antiseptic precautions, I felt that I could pass the needle through the peritoneum with safety. About one quart of urine was removed from the bladder. A drop of blood followed the removal of the needle, the point of puncture was covered with a strip of adhesive plaster, and the patient went to sleep. Next day his bowels moved freely and he passed considerable urine, a part of which escaped into the bed and could not be measured.

The morning of the second day after the operation, he complained of pain in the lower part of the abdomen, and tenderness. Bladder could not be felt; pulse somewhat acceler-

ated; temperature normal. Toward evening abdomen became tympanitic, pulse more rapid, temperature 98, expression anxious, urine passed in small quantities. Bladder could not be made out. Opium given to relieve pain, and heat applied to abdomen. Patient died next morning, sixty-two hours after the aspiration.

Post-mortem—Needle had entered the abdominal wall two inches above the upper border of the symphysis pubis. A line of light extravasation marked the track of the needle through the wall and parietal peritoneum fold; further than this, its track could not be positively determined, as the pelvic cavity was filled with blood. Dense adhesions bound the bladder in all directions, which required considerable force to be broken up. There was considerable redness of the parietal and visceral peritoneum in the vicinity of the bladder. No pus or urine apparently. In freeing the adhesions about the bladder, that organ was ruptured, and about 1-2 pint of turbid urine escaped. I removed the bladder and urethra *en masse*, but was prevented from further examination by friends who came to claim the body. I regret that I did not at least secure one of the kidneys, as it might have thrown some light on the cause of death.

There have been a number of deaths reported from supra-pubic puncture for the relief of a distended bladder. Deneffe and Van Wetter, in 1877, collected one hundred and fifty-two cases of supra-pubic puncture with six deaths; eighty-seven cases of rectal puncture with eleven deaths. I have not been able to find another case of accident from aspiration in the literature, though my search has not been by any means exhaustive. Deneffe and Van Wetter report fifty-seven cases of aspiration with no accident, showing the improvement upon puncture. The case here reported, proves at least that aspiration is not free from danger, and suggests greater circumspectness in its practice.

DR. W. P. CHUNN: In these cases of distended bladder, by sticking close to the symphysis, you can get into the bladder without striking the peritoneum at all, and this is what most operators attempt to do. In this case under consideration,

some urine probably trickled out of the bladder and gave rise to peritonitis.

DR. J. W. CHAMBERS: I begin to look upon every case of greatly distended bladder in old men with enlarged prostate with a certain amount of apprehension. The condition is a dangerous one. The case in point is interesting, from the amount of hemorrhage that followed a simple aspiration. The condition of the veins over the front of the bladder can be very aptly compared to the condition of the veins in front of the trachea, where we frequently meet irregular veins which give rise to considerable trouble in operations. In the present case, with an enlarged prostate interfering with the circulation, the veins on the anterior surface of the bladder were doubtless distended, and probably one of these varicose veins was punctured, giving rise to the hemorrhage. The peritoneum was probably infected by the needle which became infected in the bladder. Ordinarily, a puncture two inches above the symphysis, when the bladder is distended, would not strike the peritoneum, as there is then usually two and one-half to three inches space between the symphysis and the peritoneal reflection.

DR S. K. MERRICK read a paper on "Idiopathic Pericarditis," with report of two cases.

The term idiopathic pericarditis is used by authors to define an inflammation of the pericardium (which may be acute, sub-acute or chronic) not the result of any discernible preceding or concomitant pathological process. To eliminate every etiological factor in any given case, and by exclusion arrive at a diagnosis of idiopathic pericarditis, requires no little pains on the part of the practitioner. Not a few authors are skeptical as to its existence. Da Costa, while admitting its extreme rarity, says he has seen several cases about which he has no doubt as to the diagnosis. It may be that the paucity of cases of this affection reported, depends in no small degree upon the obscurity of the symptoms and latency of the affection, which may possibly be characteristic of this form of pericarditis.

Case 1. Widow, aged 60. Came under observation at the North Western Dispensary, in early part of 1887. Com-

plained of pain in the precordial region, of great weakness and faintness on exertion, and that her hands and feet were always cold. She had had no acute illness for years. Never had rheumatism, nor any of the diseases which stand in an etiological relation to cardiac diseases. Her urine was examined and was found normal. Careful auscultation discovered no valvular lesions. All the valvular sounds were clearly audible, but weak. The apex beat was in the normal position, but lacked force. The diagnosis made, was weak heart from malnutrition, the latter being due to some unknown cause. She was slightly jaundiced, her skin being very much like parchment. She grew gradually weaker and progressively emaciated, the coldness of the extremities reaching up to the elbows and knees. To the touch she was more like a cold-blooded animal than the *genus homo*. Her urine was repeatedly examined, and was always normal. She entered the Maryland General Hospital, in the fall of 1887, and died about three months later. The autopsy was held by the late Dr. E. R. Walker. The heart and lungs were removed, the latter being sound and free from adhesions to the pleuræ or pericardium. The valves of the heart were perfectly sound, but the walls of the heart were atrophied and thin, and on close examination there was found an uniformly adherent pericardium, which could be peeled off. The whole organ was firmly compressed by the adherent sac. All other organs were normal, except the liver, which on close examination was found to contain small points of scar tissue here and there, the sites of former localized hepatitis, no doubt. The coronary artery had doubtless been compressed by the adherent sac, and thus the nutrition of the heart had suffered.

Case 2. Widower, aged 42, salesman in clothing house. Admitted to the Maryland General Hospital, Nov. 10, 1891. His health had been good until three weeks previous, when he had considerable pain about the precordia. Said he had no fever at any time. Temperature was always normal while he was in the hospital. Urine normal. Man had never had rheumatism, nor any disease to which pericarditis could be referred. No apex beat discovered by inspection or palpation. No friction fremitus on palpation. On per-

cussion, an increased area of dullness over lower cardiac region. Auscultation revealed the two and fro new-leather sound heard with increasing loudness, as the ear approached the base from the apex. A rather loud aortic regurgitant murmur was heard in the second right intercostal space, the blowing character of which was in sharp contrast to the pericardial friction sound. I pronounced it a case of pericarditis with effusion, complicated with endo-carditis and aortic valvular lesions. Dr. Street, who also examined the patient, came independently to the same diagnosis. The patient, a few days after coming under my care, disobeyed certain rules of the hospital and was dismissed, much to my regret.

DR. W. T. HOWARD, JR.: I thought that the lesions described in the liver in the first case were suggestive of syphilis. If this case could be associated with syphilis, it would be most interesting, as syphilis has never been set down as a cause of pericarditis.

Dr. MERRICK: I could not exclude syphilis. There were no symptoms of syphilis as long as the case was under my care. The lesions were on the surface of the liver, and dipping down a quarter of an inch or so. Dr. Walker, who made the autopsy, thought they were the sites of hepatitis.

DR. HOWARD related a number of cases of adherent pericarditis, which had come under his observation.

DR. A. K. BOND: I have no doubt at all, that Dr. Merrick's cases were cases of idiopathic pericarditis. One cause of pericarditis and endocarditis that might sometimes be mistaken for idiopathic, is rheumatism, where there is no associated joint pains. In a case under my observation this winter, I found signs of an old pericarditis. The patient told me that these signs had been present since childhood. She said she had never had rheumatism. As in infancy and childhood rheumatism sometimes manifests itself, not in joint pains, but by other symptoms, such as chorea, I asked the patient if she had ever had St. Vitus' dance. She replied that she had had several very obstinate attacks.

DR. CHARLES O'DONOVAN quoted from Ziemsen, Loomis, Gowers and others, to show the extreme infrequency of idiopathic pericarditis. In Dr. Merrick's first case, a very con-

siderable amount of trouble was found in and about the liver, and it seems hardly proper to record this as a case of acute idiopathic pericarditis. The second case was not the subject of autopsy, and is, therefore, incomplete. It is quite possible that some cause may have existed which was not detected. It is very plain in my mind that the first case was not one of idiopathic pericarditis.

DR. J. F. MARTENET: In ten years special work in chest troubles, I have never come in contact with a case of idiopathic pericarditis. I should think that the first case of Dr. Merrick was of syphilitic origin. I do not know that Dr. Merrick has eliminated chorea. We scarcely ever have a case of chorea, persistent in character, in which we do not have some trouble in the heart area. Dr. Osler says that one should look for troubles in the cardiac region, associated with, and following chorea. It seems to me that there must be some other affection, possibly early in life, that he has not traced out.

DR. HOWARD, JR., thought it extremely improbable that a case of idiopathic pericarditis ever occurs. The second case, in which there was no autopsy, he thought must be excluded.

DR. J. W. CHAMBERS: It seems to me that the interest in Dr. Merrick's case is not so much the cause of pericarditis, but the fact that this woman died, and the principle lesion was in the pericardium. Lesions of the heart, endocardium, pleuræ, kidneys and other organs, which are usually associated with pericarditis, were absent. "Idiopathic" is simply a waste basket, in which we throw things for convenience. Undoubtedly this trouble had a cause, but what the doctor means to say, is that he could not find out the definite cause.

DR. O'DONOVAN: I think Dr. Chamber's remarks are hardly *apropos*. The whole world is searching for a case of idiopathic peritonitis, and as far as I know, they have not been able to find it. The same holds good as to pericarditis. It is hardly the thing to claim these cases as almost isolated cases of a very rare disease. Every case should be judged on its merits.

DR. CHAMBERS: Since the whole world is looking for a thing and has not found it, it shows that it is not particularly

interesting to the general practitioner. The point of interest I still think is, that in that particular case the only lesion was an inflammation of the pericardium.

DR. O'DONOVAN: There was liver trouble.

DR. CHAMBERS: The marked lesion was in the pericardium.

DR. NORMENT: With Dr. Chambers and Dr. O'Donovan, I doubt if there is idiopathic anything, if by "idiopathic" is meant a disease without an underlying cause. The question of associating a previous illness with the case in hand, is an interesting one. Dr. Howard said that he knew of no case in which syphilis has been recorded as a cause of pericarditis. If syphilis was likely to be a cause of pericarditis in the present case, it seems to me that it would have been the cause of it in a good many other cases as well, considering the prevalence of syphilis. If a man had syphilis twenty years ago, pneumonia ten years ago, typhoid or what not five years ago, and there is not a chain connecting these diseases with the disease that takes him off, it seems hardly fair to attribute lesions that are present to-day to something that happened long since. When we cannot say what is the matter, it is better to say that we do not know; and it is in this sense, that the word idiopathic is used to-day, rather than in a definite sense.

DR. MERRICK: With regard to syphilis, in searching over the authorities, I could not find syphilis as ever having been the cause of pericarditis. As to rheumatism in childhood, that is readily disposed of by the character of the adhesions, which showed the trouble to be of recent date. I grant what the gentlemen have said of the extreme rarity, and perhaps the impossibility, of idiopathic pericarditis. All of Dr. O'Donovan's authorities acknowledge that such a thing may occur. Da Costa says there are cases in which the closest investigation has failed to show any assignable cause. In twenty years practice, during twelve or fifteen of which I have had all the clinical material of the North Western Dispensary, averaging 4,000 to 6,000 cases in a year, I have had an opportunity of getting hold of such a case, if

such a thing exists. Dr. Walker, who had made over 3,000 post-mortems, particularly noted this case in the hospital, and that was the reason an autopsy was held. The case was an unique one in Dr. Walker's experience.

WM. T. WATSON, Sec'y.

1519 N. Broadway, Baltimore, Md.

THE AMERICAN HEALTH RESORT ASSOCIATION.

Journal of the American Medical Association, July 16, 1892.

This Association met at the Tremont House, Chicago, June 30, and held three sessions.

There were present delegates representing Canada, Michigan, Massachusetts, Wisconsin, Florida, New Hampshire, New York, Pennsylvania, California, Illinois, Vermont, Colarado, Texas, Iowa, New Mexico and Central America.

A large correspondence was read by W. A. Chatterton, Secretary, from the absent members in various parts of the country.

The President, T. C. Duncan, M. D., of Chicago, then delivered a lengthy address, in which he outlined the good work of the Association, and how it was appreciated by the profession, enabling them to select climates adapted for the various cases of consumption. From reports received from the winter points, New Mexico had proven the most satisfactory. This is of interest to the profession who are trying to save some of the "hundred thousand consumptives" who die annually in this country.

Dr. J. F. Danter, of Toronto, Canada, read a paper on the "Climates and Resorts of British America."

A report on the climate of Manitoba was read, from Dr. Clark, of Winnipeg.

The climate of New Brunswick was presented by Dr. J. Z. Currie.

From these reports it seems that there are a large number of consumptives in Canada, especially in the Eastern provinces.

Dr. Adam Miller read a paper on "Sun-spots and magnetic influence in Disease."

The climate of Nebraska was presented by Dr. Brown.

The climate of California and its resorts was presented in papers by Drs. J. D. Hartley and S. W. Andrews, of Chicago.

Dr. W. P. Roberts, of Boston, read a report on the climate of New England, in which he reported that 15,000 die annually there from consumption.

"Consumption in Michigan" was the subject of a paper by Dr. Veenboer.

Dr. O. W. Gordon, of Council Bluffs, reported his disappointment in visiting various resorts, and spoke highly of New Mexico.

A report from Dr. A. Petin, of Las Cruces, N. M., formerly of Paris, was read, in which he said they had almost constant sunshine, less than two inches of precipitation in twenty-eight months, and that consumptives sent there were all doing well.

A report on the Adirondack region was read from Dr. Skinner.

Dr. B. W. James, of Philadelphia, contributed a paper on "Climate Maxims."

The climate of Costa Rica was presented by Dr. Buchanan.

Dr. A. S. Butler reported on the climate of Honduras.

"Texas as a Resort for Consumptives," was the title of a paper by Dr. Marshall.

Reports on mineral waters were presented from Las Vegas Hot Springs, N. M., Eureka Springs, Ojo Caliente Hot Springs, N. M., Costa Rica and Londonderry.

Prof. I. N. Danforth gave an address on "Mineral Waters, their Analysis and Uses."

He said the profession was being imposed upon by imperfect and fraudulent analysis. In the first stage of Bright's disease he thought that bland water should be used, and in the second lithia waters.

Prof. W. S. Haines made a valuable report on "Bacteria in Mineral and Potable Waters." In some mineral waters he found two bacteria to the cubic centimeter, and in some drinking water he found as high as 8,000.

A large number of members were admitted.

It was reported that a Congress of Climatologists would

meet in Chicago next year, and it was voted that the Association meet with it.

The following officers were elected: T. C. Duncan, M. D., President, Chicago; J. F. Danter, M. D., first Vice-President, Toronto, Canada; I. N. Danforth, M. D., second Vice-President, Chicago; W. P. Roberts, M. D., third Vice-President, Boston, Mass.; T. S. Hoyne, M. D., Treasurer, Chicago; W. A. Chatterton, Recording Secretary, Chicago; J. D. Hartley, M. D., Corresponding Secretary, Chicago; W. W. Van Baun, M. D., Philadelphia; Prof. W. S Haines, M. D., Chicago.

The full proceedings and papers will be published shortly, and all members will be supplied with these valuable and interesting transactions. For further particulars, address

J. D. HARTLY, M. D., Corresponding Sec'y.

1204 Milwaukee Ave., Chicago, Ill.

THE PATHOGNOMONIC SIGNS OF PERFORATING APPENDICITIS.—Dr. Simon Baruch (*Med. Record*) emphasizes the point that symptoms of shock, carefully looked for, may always be found in perforating appendicitis. These are as follows: The countenance is anxious, the finger-tips, nose and ears are cool; pulse and respiration are out of proportion to temperature, the right inguinal region is very tender, the patient usually lies with the right leg drawn up. Guided by them, Dr. Baruch opposed the views of an experienced physician in one case, insisting upon the operation; and in another did not approve of the operation advised by an experienced surgeon. In both cases his reliance on these pathognomonic signs proved useful to the patient. On the ground of his own experience, as well as that of others, the author urges that when perforating appendicitis is diagnosed, either positively or probably, an immediate operation to remove the exciting cause is as imperative as ligation of the vessel in hemorrhage.

The fact that laparotomies are now constantly performed, under strict asepsis, with absolute safety, should induce the attendant to clear up a doubtful diagnosis of perforating appendicitis by an operation before septic peritonitis forbids it.—*Int. Jour. of Surgery.*

BOOK REVIEWS.

INTERNATIONAL CLINICS.—Edited by John M. Keating, M. D., Colorado Springs, Col.; Judson Daland, M. D., Philadelphia; J. Mitchell Bruce, M. D., F. R. C. P., London, Eng.; and David W. Finlay, M. D., F. R. C. P., Aberdeen, Scotland. Vol. I, Second series, 1892. J. B. Lippincott Co., Philadelphia.

THIS publication, just entering its second year, presents its usual neat appearance and an array of contributors that bespeaks for it the high character of its contents. The articles, as heretofore, are divided into the general headings of Medicine, Neurology, Pediatrics, Surgery, Genito-Urinary and Venereal Diseases; Gynecology and Obstetrics, Ophthalmology, Laryngology and Dermatology, and is altogether very conveniently arranged. We bespeak for the second series the popularity and ready sale which so distinguished the first. C. E. J.

TRANSACTIONS OF THE SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION.—Vol. IV. Fourth session, held at Richmond, Va., November 10, 11 and 12, 1891.

RARELY has an Association, even of much greater age, made a record equal to the one as is shown by this volume of Transactions. Organized a little less than five years ago, its success has been phenomenal, and to-day its members are recognized as among the leading lights of the profession on the American continent.

To Dr. W. E. B. Davis, of Rome, Ga., one of our most skilled abdominal surgeons, who was one of the original projectors, and who has been its Secretary since organization, is due much credit for the unremitting manner in which he has toiled for the success of this Society. C. E. J.

THE POCKET PHARMACY, WITH THERAPEUTIC INDEX.—By John Aulde, M. D. Published by D. Appleton & Co., New York.

THIS little book comes to us in nice dress and convenient size; well printed upon good paper.

The author takes up some two dozen different medicines.

and two or three compounds, and endeavors to give the various pathological conditions, for which the remedies are suited; advocating their use in small and oft repeated doses. The author expresses the hope that the work may be especially useful to the recent graduate, supposed to be "intellectually rich, but technically poor." We fear that the graduate will close the book with the belief that almost any one remedy treated by the author will be ample for the needs of an ordinary practitioner, but he will be unable to decide which one to select, they are all so good.

When we turn to calcium-sulphide and find it recommended for sixty-four different diseases, among them amenorrhœa, deafness, glanders, pertussis, phthisis, pneumonia, sterility, syphilis, tooth-ache and typhoid fever, and close by, find our old friend *calomel* recommended for only thirteen different affections, we are led to believe that an invidious distinction has been made in favor of the calcium sulphide.

L. H. J.

DISEASES OF THE NERVOUS SYSTEM.—By J. A. Ormerod, M. D., Oxon., F. R. C. P., London, Medical Registrar and Demonstrator of Morbid Anatomy at St. Bartholomew's Hospital; Physician to the National Hospital of the Paralyzed and Epileptic, Queen Square, and to the City of London Hospital for Diseases of the Chest, Victoria Park. Published by P. Blakiston, Son & Co., Philadelphia, Pa.

THIS work is good. Professor Ormerod has succeeded in condensing a remarkable amount of thought and knowledge in a very few pages. This work, like most condensed essays, fails at times to give as elaborate description as might be desired; but space oftentimes compels an author to abbreviate description, when he might otherwise do himself greater justice and his readers good.

We have seen no work on the subject which gives more substance in the same space. His figures and diagrams are well wrought and instructive, and his anatomy up to the latest investigations.

H. H.

DISEASES OF THE EYE.—A Hand-Book of Ophthalmic Practice, by G E. DeSchweinitz, M. D., Professor of Diseases of the Eye, Philadelphia Polyclinic; Ophthalmic Surgeon to Children's Hospital, and to the Philadelphia Hospital; Ophthalmologist to the Orthopædic Hospital and Infirmary for Nervous Diseases; Lecturer on Medical Ophthalmoscopy, University of Pennsylvania, etc.

AS A TEXT-BOOK for students and practitioners, this volume will gracefully take its place along with the well known text-books of to-day. While the author has not impressed us with that originality desired generally in book-making, yet the lucid manner in which the diseases of the eye and its defects are presented, shows much skill and ingenuity; and we feel justified in saying that it fully subserves the purpose for which it was intended, and heartily recommend it to students and practitioners. The book is substantially bound, printed in large, clear type. Published by W. B. Saunders. Philadelphia.

A. B. P.

MILK: IS ITS STERILIZING NECESSARY?—Dr. Freudenreich, after a series of experiments on the action of raw milk on bacteria, has come to the conclusion that it possesses remarkable germicidal properties. He claims that the bacillus of cholera in fresh cow's milk dies in an hour; the bacillus of typhoid fever in twenty-four hours, while other germs die at the end of varying periods. He further found that milk exposed to a temperature of 131 degs. F. loses this germicidal property, as also milk that is four or five days old.

These experiments will set the physicians to thinking very seriously on the advisability of sterilizing milk for infants' food, or for food of adults. We were just congratulating ourselves on the fact that a means of preventing the introduction of disease into the human body through milk had been discovered in sterilization. According to Dr. Freudenreich, one might conclude, at first thought, that we were mistaken in our expectations and confidence, and that raw milk is, after all, preferable for human consumption.—*Bacteriological World.*

Selections and Abstracts.

CHLORINE IN COMBINATION WITH PHENIC ACID —THE IDEAL ANTISEPTIC AND DISINFECTANT.

J. E. Chambers, M. D., coroner's physician of St. Louis, speaks as follows on this subject:

The term "antiseptic" is no longer doubted as a medical term; nor is there longer a doubt of the value of antiseptics in surgery, midwifery, or the hygiene of the sick room.

The victory of antiseptics is the greatest triumph achieved by scientific medicine in an age of triumphs, and so numerous are the antiseptic preparations that have sprung up, that the question of what antisepsis is, changes to the question of the selection of an antiseptic agent.

The nearer we keep to nature, the fewer mistakes we make. In calling nature to our aid, we find that chlorine in the shape of the various chlorides, is nature's great antiseptic. Were it not for the chloride of sodium—common salt—in any ocean, it would be one seething mass of corruption, and the present invigorating sea-breeze would create a pestilence capable of removing all the higher orders of life from the face of the earth.

Ages before the terms "septic" or "antiseptic," were known or used, our ancestors were practicing antisepsis with chloride of sodium, without knowing the philosophy of its action, and were nearer to nature than many scientists of our scientific era. The antiseptic property of chloride of sodium is inherent in the chlorine; sodium, like lime and mercury, having no antiseptic properties. The more ready a chloride is to decompose and give up its chlorine, the more marked are the antiseptic properties of that chloride: All the chlorides are now classified as antiseptics, while the bases of the various chlorides are usually inert, antagonistic to antiseptic action, or so irritating to the tissues as to unfit them for use in medical or surgical practice.

Chlorine has no rival as an antiseptic, but in its free gas-

eous form it is difficult to manage, while in its compounds are found the objectionable features of the bases, with which it is combined.

Following nature, custom and common sense, it has been a maxim from Biblical days, that "Cleanliness is next to Godliness." Water being easily impregnated with chlorine, "chlorinated water" was highly recommended for cleansing foul ulcers, before anything about antiseptics was known.

The cleansing property of water is well known, and the master of antiseptics for medical and surgical practice is a carbolized chloro-oxide of hydroxyl, known as chloro-phenique. In this preparation are all the elements that go to make up an ideal antiseptic, viz.: carbolic acid in sufficient quantity to anæsthetize the exposed nerve fibres, and to reduce the local temperature, and chlorine gas held in suspension sufficient to destroy all septic material. A ten to twenty per cent. solution is a valuable wash to all ulcerated mucous surfaces, such as the mouth, nose, or throat, or as an injection into vagina, uterus, bladder or rectum, in an ulcerated or inflammatory condition of these organs. Its value as a disinfectant cannot be estimated, as it gives off by evaporation sufficient of its gases to disinfect the sick room, and rid it of all offensive or poisonous odors. If the chlorine odor is offensive to the patient, that objection may be met by any suitable perfume.

Chloro-phenique is strong enough in its undiluted state for any case or condition in surgery or medicine calling for antiseptics or disinfectants, while minor conditions are met by solutions of various strengths.

In summing up the qualities of chloro-phenique we find, first, that in its use we are but following nature's laws; second, that it can be made of any desired strength or solution; third, that its disinfectant are equal to its antiseptic properties, and last, but most important, its volatile properties render the atmosphere sterile in the vicinity of the wound to which it is applied, equal to the action of a constant spray.

In conclusion, allow me to say that chloro-phenique, as an antiseptic and disinfectant, has no superior, and we need no other.—*The International Journal of Surgery.*

TREATMENT OF RHEUMATISM.

BY CHAS. W. BROWN, M. D.

October 20, 1891, saw Mrs. H., of this city, aged 44 years. Found her suffering from rheumatism; there was pain, redness and swelling in both knees and ankles. Temperature 103, skin hot and dry, considerable thirst; urine scanty and high colored. She said she had been subject to such attacks for several years, whenever exposed to wet and cold weather, and the duration of the attacks was from three to six weeks; and she had been confined to her bed for several weeks at a time. For five days previous to my first visit she had been treated by salicylate of sodium, aconite and opium, without any perceptible benefit. I prescribed W. R. Warner's Elixir Salicylic Acid Comp., a dessertspoonful every four hours, and gradually increased the dose to a tablespoonful. In less than twenty-four hours she was perspiring freely, the temperature fell to 99, and she was free from pain; the urine became more abundant, and lighter in color, the swelling of the joints rapidly disappeared, and in one week she could walk without difficulty. She continued to take the elixir for two weeks longer, in dessertspoonful doses, three times a day, and has had no return of the disease up to this date.*

Case 2—Mrs. G. W. D., aged 28 years, Elmira, N. Y., October 11, 1889. Had acute rheumatism; swelling and redness of knees, ankles and feet, also left hand and arm perfectly helpless; pain severe and constant; temperature at first visit 104½, pulse rapid and irregular, occasional sharp pains through left breast. Prescribed Warner's Elixir Salicylic Acid Comp., tablespoonful every four hours, quinia sulph., gr. ij, every four hours. Fomented limbs by means of

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*Elixir Salicylic Acid Comp. is an elegant preparation, composed as follows: Each tablespoonful contains 24 grs. Salicylate Sodium, so combined with cimicifugæ, potass. iodide and gelseminum as to avoid all unpleasant results, such as gastric and intestinal irritation, nausea, delirium, restlessness and rapid breathing, which so often follows the administration of salicylic acid.

The dose is from a tablespoonful to a teaspoonful, as the case may require. Prepared by Wm. R. Warner & Co., Manufacturing Chemists, Philadelphia and New York.

flannel cloths wrung out of hot salt water. She improved from commencement of treatment, and walked out on the street ten days later, and has had no return of the disease.

Case 3—G. W., locomotive fireman, aged 25 years. Was called to treat him March 22, 1888. He has been unable to leave his bed for two weeks; ankles and feet were enormously swollen and red, very tender to touch, and painful. So he was obliged to take full doses of opium to obtain sleep. Prescribed Warner's Elix. Salicylic Acid Comp., f oz. vj; Potas. iodidi, dr. iij. M. Sig.—Tablespoonful every six hours. Fomentations as in former case. In a week he was able to walk about, and two weeks from beginning of treatment he went to his usual work as fireman on railroad. This man had gonorrhœa, when swelling of ankles came on after he had his clothing wet through by being out in a storm of sleet and rain, and the discharge suddenly stopped, and did not return until profuse perspiration took place as a result of treatment and reduction of temperature. This discharge continued for ten days after he commenced work, but finally yielded to appropriate treatment.

Case 4—J. O. D., woman, aged 45 years. Chronic rheumatism, right leg and hip; also both hands. Been helpless for eight months. Has tried various plans of treatment without material benefit. Ordered tablespoonful of the elixir four times a day (added to each twelve-ounce bottle, dr. iij., potas. iodidi); also gave 2 gr. pill quinia sulph. three times a day. She gradually improved, and in four weeks was able to go up and down stairs without difficulty, though the enlargement of joints remained for several months. She continued to take the elixir for four months, and has had no return of the disease sufficient to prevent her from being around and being able to perform her usual household duties. She has had, occasionally, symptoms of a return of the lameness, but has been relieved by taking the remedy for a few days.

902 Fourteenth St., N. W., Washington, D. C., December 14.

N. B. Wm. R Warner & Co. promise to send some of this elixir for gratuitous use to any physician who has an obstinate case of rheumatism to treat.—*Southern Clinic.*

THE TREATMENT OF GONORRHŒA.

BY DR. JOHN A. WYETH, AT THE N. Y. POLYCLINIC.

My idea about gonorrhœa is that we should treat it just as we do an acute abcess; that is, by drainage, with just as much asepsis as possible. Let the urethra hang downwards, with a bag of some sort loosely attached to it to catch the discharge. Do not have it tightly bandaged or plugged up with cotton. In a specific urethritis, where the inflammation has extended into the deeper layers of the epithelium, the various bich oride and zinc injections are not likely to do much good. In an ordinary, non-specific urethritis, however, where the inflammation is superficial, you can inject with good results. There are certain remedies which will increase the amount of urine and render it aseptic, so that you can use the bladder as an irrigator in gonorrhœal inflammation. Among these remedies is boracic acid, or, better still, the oil of gaultheria This drug will absolutely sterilize the urine. You can give five or six drops every three or four hours. During the later stages of the inflammation, mild solutions of the sub-acetate of lead can be used, which will help keep the urethra clean. A syringe with a short nozzle should be employed, so as to only just enter the meatus. The injection should be of moderate size, so as not to over-distend the urethra. During the acute stages, I instruct my patient to take a warm sitzbath night and morning. When the acute stage has subsided, the administration of some of the so-called blennorhetics will be found beneficial.

I have found the capsules containing santal-midy, a preparation made from sandal-wood, a very good thing. I consider these superior to the old-time cubeb preparations, which are liable to disturb digestion.—*Ex.*

ASAFŒTIDA is recommended in habitual abortion not due to syphilis or disease of the uterus and its appendages, by Dr. Guido Turazza, in *Centralblatt fur Gynœcologie.* He administers it in 1¼ gr. pills every other day at first, and increases the interval gradually to ten days during the whole period of gestation.—*Notes on New Remedies.*

THE TREATMENT OF GONORRHŒA.—My treatment of gonorrhœa in all stages has for long been very monotonous. Almost without regard to stage or degree of severity, I prescribe the same remedies. I have long ago laid aside the traditions of my student days, which taught that salines only should be used in the acute stages, and that abortive plans were dangerous. I always use abortive measures, and mostly, I believe, succeed. At any rate, I never encounter ill consequences, and complications are rare. My prescription is a partnership of three different remedies, and it is, I believe, important that they should all be used. First, an injection of solution chloride of zinc, two grains to the ounce ; next, sandal-wood oil capsules ; and lastly, a purgative night dose, with bromide of potassium. The injection is used three or four times a day, the capsules (ten or twenty minims,) taken three times a day. The ingredients of the night dose are three drachms of Epsom salts and a half drachm of bromide of potassium. It is, I believe, the action of the last named in preventing congestion of the parts, which makes the abortive measures safe.

Moderate purgation and entire abstinence from stimulants are essential. If the case is very acute, and attended by swelling of the corpus spongiosum, I sometimes prescribe tartar emetic, or tincture of aconite, but it is very seldom, indeed, that these are necessary. If the patient be well purged, there is no risk whatever in an abortive treatment from the day he comes under treatment. The risk of orchitis, prostatitis, cystitis, etc., comes in cases which have been allowed to develop rather than in those treated abortively. I should as soon think of delaying to use local measures in gonorrhœa, as I should in purulent ophthalmia.—*Johnathan Hutchinson, in Archives of Surgery.*

INJECTION OF ALCOHOL IN UTERINE CARCINOMA.—Dr. H. Schultz, in *Centralblatt fur Gynœcologie*, makes a preliminary report of the treatment of uterine carcinoma with injections of absolute alcohol. In one case of disease of the cervix there was a complete cure. In nine other cases, which are still under observation, there is marked improvement. The injections are made deep into the affected tissues.—*Notes on New Remedies.*

Editorial.

OBSERVATIONS UPON SURGICAL MEASURES IN PHILADELPHIA.

A few comments upon surgical practice are suggested by a stay of two weeks in Philadelphia, and daily observations of operations by various prominent surgeons. The first notable feature is the general use of ether anæsthesia, with the exception of the employment of bromide of ethyl in certain cases by Dr. E. E. Montgomery. He follows in this, the lead of Chisholm, of Baltimore, who in a conversation at Detroit, urged upon me the safety and efficiency of this agent, not only in his specialty, but in general surgery. The results of Sims and Levis, some years ago, caused such fears of the consequences of bromide of ethyl inhalations, that few have since resorted to it. But I am assured by the above named operators, that this apprehension is without just foundation.

Again, it was observed that surgeons generally, and especially gynecologists in Philadelphia, employ simply sterilized water for all operations in which there is not already an infected or septic condition of the tissues involved, and no antiseptic is used in washing normal structures during an operation, in whatever part it may be. It was noted, however, that Ashhurst used a douche of a weak solution of bichloride of mercury, after excision of the knee joint, involved in suppurations with an extensive sulcus extending up between the muscles of the thigh. If bichloride washes are limited to septic surroudings, less trouble may be expected from poisoning, than occurs under the indiscriminate resort to this antiseptic agent.

In gynecological work, it was observed that the Prices use white silk ligatures in securing pedicles and pus tubes within the abdomen, while Montgomery employed cromatized cat-gut in these cases, as well as to close the external wound. Each of them make a point of suturing the intermuscular fascia separate from the deep through-and-through sutures which

include the peritoneum. My individual experience favors the closure of the peritoneum with continuous cat-gut suture apart from the other tissues, so as to allow the natural mobility of this membrane in its union by first intention at the outset

It was observed in the Pennsylvania Hospital, that water dressings were still employed in the treatment of contused wounds and inflammatory conditions of the extremities, whereas the dry applications are generally adopted with good results. Since the fatal pneumonia in Stonewall Jackson's case, from the moisture caused by water dressing of his amputated arm, it has impressed most surgeons that this mode of treatment is more honored in the breach than by the observance.

The old time fracture box, and the resort to extension, by the weight and pulley, in fracture of the lower extremity, continues to be used in this institution. But I had the satisfaction to witness a very neat and efficient application of plaster of-Paris dressing with zinc plate stays, by Dr. Packard, in a fracture of the tibia. It was not made so thick and strong as I saw in New York some years ago applied by Dr. James R. Wood, who stood upon the plaster mould with his entire weight, to illustrate its strength, when I was taking the round of the hospital with him. The lighter plaster dressing can be made the better, and in this respect, the mode adopted by Dr. Packard fulfilled the indications admirably. The plan of suspension for fractures of the leg is also adopted with good results.

An impression is growing with the profession generally, that there is too much operating upon the abdominal cavity by gynecologists, and that the risks of oophorectomy and removal of tubes should be avoided by a resort to other modes of treatment, whenever practicable.

In the brief period of two weeks observation, it so turned out that I witnessed the fatal result of three abdominal sections, on account of purulent conditions involving the ovaries, tubes and peritoneum. These operations were in different places and by different parties, with such complications that they would almost certainly have terminated fatally

without interference, but they seem to accentuate the caution against operating when it can be avoided.

Time and space will not allow further remarks at present.

J. McF. G.

THE Tri-State Medical Society of Alabama, Georgia and Tennessee will hold its fourth annual meeting in Chattanooga, beginning Tuesday, October 25th, 1892. The meeting will last three days. That it will be a success, is assured by the fact that Dr. W. E. B. Davis, the president of this young and vigorous society, is working very hard for the success of the next meeting.

The membership includes many from States other than those included in the title. Papers have been promised by the following: Drs. W. E. B. Davis, Rome, Ga.; I. N. Love, St. Louis, Mo.; J. B. Cowan, Tullahoma, Tenn.; E. B. Ward, Selma, Ala.; J. M. Head, Zebulon, Ga.; John L. Howell, Knoxville, Tenn.; C. S. Briggs, Nashville, Tenn.; J. M. Masters, Knoxville, Tenn.; Richard Douglass, Nashville, Tenn.

DR. CHAS. D. ROY left Aug. 1st for New York, where he takes a steamer for Liverpool, thence to London. After a short stay in this latter place, he goes direct to Berlin, Vienna and Munich, where for a year or more he will prosecute his studies in the eye, ear and throat. He will also go to Leipsic for a brief stay.

DR. R. R. KIME has moved to his new residence, 13 Morrison Ave., where he will shortly be prepared for the reception of a limited number of patients in the line of gynecology and obstetrics, to which he will in future limit his practice. His office will still remain at 63 1-2 Whitehall St.

DR. M. ASHBY PURSE, of Savannah, a graduate of the Southern Medical College, and more recently of the College of Physicians and Surgeons, New York, has lately came to Atlanta, where he will locate and engage in the practice of medicine.

DR. R. O. COTTER, of Macon, has been elected president of the Barnesville Bank, *vice* Hon. R. J. Powell, deceased. Dr. Cotter was a son-in-law of the late Col. Powell. By reason of this new duty, he will move to Barnesville, at least temporarily.

DR. W. E. B. DAVIS, who for some months past has been associated with Dr. J. B. S. Holmes, of Rome, in a sanitarium for the treatment of diseases of women, has decided to remove to Birmingham, where he originally practiced.

THE Mississippi Valley Medical Association will hold its eighteenth annual session at Cincinnati Wednesday, Thursday and Friday, October 12th, 13th and 14th. A large attendance and an interesting program are expected.

DR. J. A. CHILDS, of Atlanta, has been in New York some weeks, pursuing a special course in genito urinary diseases.

DR. K. C. DIVINE, of Atlanta, has decided that in future he will limit his practice to rectal surgery.

PREVENTING BLINDNESS.—An Act for the prevention of blindness has just been made a law by the Rhode Island Legislature. It is similar to the New York State law, and Rhode Island is the first New England State to adopt it. The important paragraph is the first, and it reads as follows:

"Should any midwife or nurse, or person acting as nurse, having charge of an infant in this State, notice that one or both eyes of such infant are inflammed or reddened at any time within two weeks after its birth, it shall be the duty of such midwife or nurse, or person acting as nurse, so having charge of such infant, to report the fact in writing within six hours to the health officer, or some qualified practitioner of medicine, of the city or town in which the parents of the infant reside."

It has been called the "Sore-Eyes Bill." But as the sore eyes in question cause ten per cent. of the cases of blindness, and are the largest single factor, they naturally deserve special, if not legislative, attention.—*New York Medical Record.*

Books and Pamphlets Received.

The Operative Treatment of Goitre, by J. Collins Warren, M. D., Boston, Mass.

Biographical Sketch of John C. Hupp, A. M., M. D., of Wheeling, W. Va.

Transactions of the American Dermatological Association, at its fifteenth annual meeting, held at the Shoreham Hotel, Washington, D. C., on the 22d, 23d, 24th and 25th of September, 1891.

The Treatment of Tuberculosis of the Bones and Joints by Parenchematous and Intra-articular Injections, by N. Senn, M. D., Ph. D., Chicago, Ill.

The Effect of Fluids on the Strength of Catgut, by D. Braden Kyle, M. D., Philadelphia.

Otitis Media—Abscess of Neck—Death, by E. Oliver Belt, M. D., Washington, D. C.

The Mission of the Association of Military Surgeons of the National Guard of the United States, by N. Senn, M. D., Ph. D., Chicago, Ill.

One Hundred and Fifty Circumcisions and the Lessons they Teach, by B. Merrill Ricketts, M. D., Cincinnati.

Hepatic Abscess—Report of a Case, with Remarks upon the Amœba Coli, by William A. Edwards, M. D., and James Sears Waterman, M. D., San Diego, Cal.

An Operating Table for General and Gynecological Surgery, adapted to give the Wendelenburg Posture, by Clement Cleveland, M. D., New York City.

Proceedings of the Florida Medical Association, Session 1892.

Report of Twelve Cases of Herniotomy, by B. M. Ricketts, M. D., Cincinnati, O.

What to do in Case of Accident, by B. Merrill Ricketts, Ph. D., M. D., Cincinnati, O.

Essentials of Medical Diagnosis, by Cohen and Eshner. W. B. Saunders, Philadelphia.

A New Pronouncing Dictionary of Medicine, by John M. Keating, M. D., L. L. D., Philadelphia. W. B. Saunders, Philadelphia.

Special Notes.

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We desire to direct attention to the advertisement of Dr John H. McIntyre and his elegant private hospital for women, "The Caledonia." Dr. McIntyre ranks as one of the foremost men in his line, and we suggest to all who wish to refer their patients for treatment to St. Louis, that they can then be given excellent accomodations and will receive the best of medical attention.

As Bromide of Strontium seems to be destined to displace the bromide of potassium, we would specially recommend our readers to insist on having the chemically pure salts (Paraf-Javal) dispensed, or the standard solutions (dr. j to the fluid ounce), so as to avoid further accidents, as we learn that toxic effects have been caused by the dispensing of impure strontium salts, the poisonous barium being a concomitant of the strontium preparations of commerce.—*St. Louis Clinic.*

INDIANAPOLIS, IND., Aug. 23, 1890.

Gentlemen—Have tried Antikamnia in various *neuroses due* to menstrual irregularities. It calmed the nervous excitement, relieved the pains, and permitted natural sleep. I shall use it hereafter with pleasure.

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F. LYMAN BUCKLEY, M. D., N. Y.

NEPHRITIC COLIC.—It gives me pleasure to report most favorably of the utility of Sanmetto in a case of nephritic colic to which I was called. The colic lasted about twenty-four hours, during which time I had never witnessed greater suffering, accompanied with rectal and vesical tenesmus. Treatment: Chloroform to relieve spasm, and Sanmetto every two hours, with hot formentations to genitals. This patient had for years suffered from prostatic troubles with painful micturition, frequently having to use catheter to relieve the bladder; all of which had greatly improved from the use of that most wonderful remedy, Sanmetto. And too much cannot be said in praise of its efficiency in all kidney and bladder troubles.

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D. H. HOWELL, M. D., Atlanta, Ga.

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S. D. Richards, M. D., Detroit.
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HAY FEVER.—By *Dr. Philpots*, France.

R. Acid boric, pulv., 2.0 (gr. xxx.)
Salicyl. natr., 2.5 (gr. xxxviij.)
Cocaine mur., 0.12 (gr. jss.)
M. f. p. Sig. To be insuflated into the nostrils.

DIPHTHERIA.—By *Dr. Bolio*, Detroit, Mich.

R. Quinini bi-bisulph., gr. xx.
Sulphuris, dr. j.
Yerbæ santæ syrup, oz. j.
M. S. 1-2 teaspoonful every three or four hours.

CHRONIC TONSILITIS.—

R. Acid tannic , gr. xv
Tinct. iodinii, gtt. ij.
Aquæ, f.oz. vj.
Glycerin, f. oz. ss.
M. S. Tablespoonful every three hours.

PALPITATION OF THE HEART.—By *Dr. T. A. Fairbairn*, San Diego, Cal.

R Tr. veratrum vir., gtt. ij.
Potass. bicarb., gr. v.
Tr. capsici, gtt. xx.
M. S. At a dose.

MENINGITIS.—By *Dr. N. S. Davis.*

R. Potassii iodidi, dr. ijss.
Tr. digitalis, dr. iv.
Tr. hyoscyami, dr. iv.
Aquæ menthæ, oz. iij.
M. S. A teaspoonful every two or three hours, in a little sweetened water.

BRONCHIAL ASTHMA.—

R. Iodide of ammonium, dr. 2.
Fl. ext. grindelia robusta, oz. 1-2.
Fl. ext. glycyrrhiza, dr. 4.
Tinct. lobelia, dr. 2.
Tinct. belladonna, dr. 2.
Syr. tolu, q. s. ad., oz. 4.
M. S. Teaspoonful three times a day; extra doses during a paroxysm. —*The Doctor's Weekly*

ASIATIC CHOLERA.—*Dr. R. W. Mitchell.*

R. Acidi sulphurici, dr. ss
Morph. sulphat., gr. 1-3.
Spts. vini gallici, dr. iss.
Aquæ destillatæ, oz. iij.
M. S. Inject under the skin of the arms, legs and over the stomach, every hour, until symptoms of the disease are relieved.

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CRACKERS

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ILLUSTRATING ARTICLE BY PROF. WOODBURY ON PAPOID.

(See Page 499.)

Plate II.

THE

Southern Medical Record.

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. XXII. ATLANTA, GA., SEPTEMBER, 1892. No. 9

Original Articles.

THE RADICAL CURE OF HERNIA, PARTICULARLY WITH CHILDREN.

BY DR. G. FELIZET, SURGEON TO TENON HOSPITAL, PARIS, FRANCE.

Translated by THOS. H. MANLEY, A. M., M. D., Visiting Surgeon to Harlem Hospital, New York.

(*Continued.*)

4th Indication—To assure a perfect obliteration of the tract.

It is for this happy result that we must make a dissection minute—I do not say a laborious dissection, which has for its object the preservation of the sac, its serous and fibrous elements. M. Championniere has insisted, with reason, on the necessity of isolating the serous structures, which he considers as the ideal operation; something difficult to realize.

Before him, M. C. B. Ball (*British Medical Journal*, 1884,) clearly described the rule for minuteness of execution, when publishing his procedure for radical cure, by tortion of the sac. The object in view is to secure the occlusion of the internal orifice, by isolating the serosa from the subjacent fascia. This idea was so natural, that long before

M. Ball, we have applied it as related by M. Legond, in 1883, and by M. Berjer, in the radical cure, after our kelotomies.

Our proceeding of tortion, which offers a surprising analogy with that of the Irish surgeon, consists in a slow twisting of the neck, through one of the folds of which a suture is carried, including the pillars on each side, and is lost from sight by being deeply imbedded in the loose, adjacent tissues.

In order to secure good results from tortion of the neck, without any harm to the serous funnel of the neck, it must be strictly isolated by a most minute dissection. That an operation for radical cure must embrace the destruction of the sac below the ligature or twist, is evident to our premising success on surgical logic; for interruption of the neck is effected and rendered permanent by the obliteration of this membrance of extreme tensity.

This delicate dissection which is indispensable always in this operation, even M. C. B. Ball himself, has not claimed priority for. We have deemed it necessary to particularly comment on the anatomical characters of this delicate membrane; how it should be ligated; how after section it quickly disappears within the abdomen, and the manner in which it responds to resistance.

We depend largely on the soft parts—the peripheral fibro-cellular tissues which have been isolated; but which have been carefully preserved, as representing an important, living mass, which blocks the tract and occludes the ring.

This mass serves an important purpose, but it, in itself, would be very insufficient if it were not for the irritation excited by the traumatism of operative interference, which swells, and thickens, and hardens it—which produces proliferation of cell elements, and causes adhesions with contractions, sufficiently solid, generally, for ordinary hernia; but especially those of children. But we believe that these adhesions and this contraction will not suffice in all cases.

Perhaps this hernial orifice is very large, and the tract very broad, or that the hernia is direct. The testes may have incompletely immigrated, being lodged above the ring, with a tendency to break through the new closure; either on one side, or through its centre. It is in this class of cases that

we must have recourse to suturing the pillars of the ring, after the method of Mitchell Banks; but which is condemned by some surgeons, whose conclusions in this matter we do not fully agree with.

Let us see what may be accomplished by this operation of approximation of the rings by suture. We must not expect union of the two pillars, without freely refreshening their edges (a union of fibrous tissues is of little importance), with a view of effecting adhesions of an intimate character, similar to reunion of a wound; forming a sort of homogeneous wall, firm and permanent; the opening will be closed, and the pillars well fused. It might, however, be legitimate to insist on suturing the pillars of the ring, not for its definite occlusion, but for the purpose of narrowing its fibrous columns; though, after all, it is but a temporary occlusion of varying duration.

The union or support effected is shaped, organized and fixed where the pillars approximate, the cellulo-fibrous cement effused, maintaining a resistance which may occasionally contribute towards a radical cure.

In infantile surgery, suturing the pillars of the ring is often a necessary operation, when the testis is incompletely descended, and its maintenance externally is important. The case here related belonged to that class.

ECTOPIC TESTICLE, RIGHT SIDE—PHENOMENA OF STRANGULATED HERNIA—RADICAL CURE—SUTURE OF THE RINGS.

Eugene Baillard, 14 years old, entered the hospital January 27th, 1889, for treatment of ectopic testis and interstitial hernia; complaining of colicky pains and other symptoms of strangulation, at time of entrance. On January 29th, the operation for radical cure was performed. A transverse incision was made; the sac ligated and excised, and the pillars sutured. Retraction downwards of the testicle was difficult, but to secure its detention in the scrotum, the ring was closed. He recovered without incident in twelve days, but remained in the hospital two weeks, in order to accustom himself to the use of the truss, which was applied with a view of pressing the testis away from the abdominal aperture.

On March 27th, patient left hospital perfectly cured, without either colic or pain; the truss discarded. He returned to us eighteen months later, July 25th, 1890. The hernia was then totally cured. The testis is on a level with the external orifice. The pillars are *more widely separated than before the operation*, so that the testis might lodge in the interspace, if drawn into it.

We can easily comprehend why a truss, badly made and badly adjusted, may contribute towards the retention of the testicle and dilation of the pillars. The truss should often be cast aside altogether, in this complicated variety of hernia. The hernia is then cured by the gradual approximation of the fibrous walls, the testis unobstructed migrates downwards; the protrusion gradually disappearing.

An infant was sent to us September 4th. The cure was deceptive and incomplete; but since the suppression of the truss, which was more painful than useful, the rent between the pillars which lodged the testicle, had very considerably diminished.

ECTOPIC TESTIS ON THE LEFT SIDE, COMPLICATED WITH INGUINAL HERNIA—RADICAL CURE.

Alfred Gras entered hospital Nov. 21st, 1889, for treatment of an external inguinal hernia, complicated with an undescended testis; the rupture is not troublesome, but the testicle is. During efforts at walking, the pains are atrocious. The right vaginal pouch was distended by serum, and contained a rudimentary testis attached to a shrivelled cord. The virility of this young man resided exclusively in the testicle on which we proposed to operate. According to the mother's testimony, this upward migration of the left testis was present but two months.

On the 23rd of November, the operation for radical cure was undertaken. The testis were found normal and exterior to the sac, which was very thin and delicate. The sac was so diminutive and fragile that it seemed impossible to ligate it. The testis was drawn downward, the intestine reduced, the pillars sutured with three strands of catgut. Result: Cure in one month. The incision did not unite by primary union,

but partly re-opened and separated. He left the hospital January 12th, 1890.

The testicle is fixed against the abdominal wall, close to the sutured orifice. It is rather indurated, slightly immovable in the mass of cellular tissue in this region. He returned to us six months later with no evident tendency of the return of the hernia. The pillars of the ring, however, are separated and the testicle, although it is not possible to draw it downward, mounts readily and is lodged in the inguinal tract, which gapes widely outward. Suture of the ring in this case, as the proceeding did not produce coalescence of the fibrous structures; but nevertheless the operation has favored a cure, for without it the neck could not be ligated nor the sac excised.

FOURTH OPERATION—HYDRATED CYST OF THE LIVER, COMPLICATED WITH CONGENITAL INGUINAL HERNIA ON RIGHT SIDE—RADICAL CURE WITH SUTURE OF THE PILLARS.

Earnest R., six years old, entered February 5th, 1889, for treatment of a large hydatid occupying the entire convex surface of the liver, and a large inguino-scrotal tumor on the right side, which gave evidences of threatening strangulation, by violent pains radiating to the lumbar region. A diagnosis of reducible inguinal hernia was made. It had attained the volume of a hen's egg. The ectopic gland was high up at the external ring. From February 5th to March 5th, treatment of the hydatid cyst was continued by puncture, aspiration and injection of Van Sweeten's liquid. Result: Cure without accident.

March 10th, operation for the radical cure was commenced. The neck of the sac was ligated with catgut The columns were approximated by three silk sutures, after the testicle was drawn towards the base of the scrotum. The testis was easily depressed and recognized as its dependent elevation was not attributable to shortening of the cord. Result: Very good.

This was a delicate child, with soft distensible abdominal walls and weak muscle. On July 8th, 1890, the child returned to know if he must continue the employment of the truss.

He had experienced no more pains and signs of strangulation since the operation. The testicle was now nearly as high as its congener. It rises and lodges in the aperture of the ring which it approaches, but does not become fixed there. There is now no hernial propulsion during effort of coughing. No truss. The infant comes to us July 18th, that we may see the consequences of laying the truss aside. The inguinal region is feeble on both sides, but one can feel on the side invaded a large projection responding to the general weakness of the girth. We advised, as a matter of prudence, that he wear a double bandage, and continue it until that age is attained when the natural forces will provide ample security.

The sutured pillars, although they did not effect definite occlusion, has permitted one to secure the radical cure, by the temporary adhesion of their margins, and the use of the truss has certainly facilitated the descent of the testes by a mechanism, indirect and curious. We would be disposed to convince ourselves that the narrowing of the ring has bound together the elements of the cord. The stricture of the cord has occasioned a veritable stasis of the mucous circulation—a species of experimental varicocele, as we have seen it during an operation for this condition, which results in increase in the weight of this organ, an elongation of the cord and finally a descent of the testis.

From the preceding review, it is evident that suture of the pillars serves as a temporary prop, which effects a useful purpose, until a radical cure is produced. Catgut and silk are not reliable. We now employ a very fine gold suture, which seems to secure a more permanent closure of the pillars. We have actually adopted two features of the *suture dorn*, and will if possible publish our results later.

5th Indication—To establish a plane of peritoneum, solid and strong, in place of the funnel of the internal orifice.

Such is the last indication. All this anatomical reposition would be wholly useless, if the parts were not most minutely adjusted, which we proceed to pass in review. This bottle-shaped infundibulum at the internal orifice may be replaced by a plane of peritoneum. This latter would suffice in restraining the protrusion if it were of sufficient strength and

in proper position; if the ligature obliterated the pedicle of the sac; for it would seem that the peritoneum may resist the formation of a hernia, although a very delicate membrane.

It would represent a wrinkled surface; star-shaped, the rays of which would be from the centre of the ligature to the neck.

But for this neck to be properly ligated so as to constitute a solid resistent mass, it is necessary that the ligature include only the peritoneum. Here, the difficulty commences. To assure the perfect dissection of this serous membrane, we must commence low, as in the operation described by C. B. Ball, in his procedure for radical cure, by tortion of the neck; though, if we do a very fine dissection, there is danger that we may overstretch or lacerate it.

If we do not effect perfect isolation, we need not hope to be able to free and detach it from the cellular elements, and from the fascia. With the correct operative mode, a complete dissection is tedious, difficult and dangerous; while an incomplete dissection does not assure independence of the peritoneal membrane; but on the contrary, leads to adhesions in the inguinal tract, which may compromise the final success and cure. The procedure which we will describe, permits us, without loss of time, to meet the indications for radical cure which we have often realized.

Our description of the manual of operation will be brief.

We have, up to the present time, put the method to the test nearly twenty times, with adults and children; and we are indebted to it for a rapidity of execution, which is an important factor in the success of these operations in both extremes of life. We avoid a slow operation—the possible wounding of the vas deferens, the vessels and nerves—as we practice it to-day. An approximate operation, and insufficient, we have seen; as a result, imperfect obliteration of the tract without complete effacement of the internal orifice, or the formation of a permanant, resisting plane.

Unsatisfactory results often depend on difficulties of dissection; and these difficulties arise from the fact that the dissection is executed in a region in which the anatomical elements are found in such great disorder, that accidents from too free-

use of the scalpel, are possible. Now, these accidents are possible, because not only are the vessels and vas deferens displaced, but because in searching for them, we may occasion a movement which may do damage.

Raise and fix the field of operation so that this may be easily stripped, and above all, that the serous sac may be dissected as freely as the peritoneum, of which it is the continuation, without tediousness; without its escape—without lacerating it; isolating it in its integrity as easily and completely as a lipoma. Such is the aim we have in view, and such we think we have attained.

DESCRIPTION OF APPARATUS.

A balloon of red rubber-gauze, thin and suple, pear-formed, having a length of a little more than ten centimetres in its long axis, and a diameter of six centimetres, at the moment of inflation. This extends from the base upward, along the sides of the sac, and forms an uninterrupted tube, communicating with an inflating tube. Such is the simple device of M. Galaut, which we have employed for more than four years. This pear passes easily through the length of the pouch to the aperture, about twenty-five centimetres, and has a volume about equal to the index finger. The rubber is of a deep red color, which permits us by its transparence, to see layer by layer of the parts as exposed. As the air-bag is not only for filling and distending the hernial sac, but it also presses forward the entire inguinal tract, to the proportion of which it is indifferent, there is no difficulty of adjustment. An ovoid from eight to ten centimetres in its great axis, of which its greatest enlargement will be inferiorly, and of which the small extremity continues as a cylinder, reduced to three centimetres; destined to lodge in the inguinal tract, and obliterate it during operation.

The apparel which we employ for children, is very small, from four to six centimetres in its long axis, with diameters of the globe and extremity in porportion. It has the advantage in a certain class of cases, when we propose to push the dissection to, or beyond the pillars, not only at its dome, but on the side, to distend equally and simultaneously the entire

sac without detriment. We have now definitely adopted this mode of proceeding, and produce the designs here.

DESCRIPTION OF THE RADICAL OPERATION FOR INGUINAL HERNIA.

Proper precautions having been taken, the patient is purged with a simple carthartic. He has taken in the evening a bath; has been shaved, if necessary. He is sounded with the catheter, to assure us that there is no part of the bladder in the contents of the sac.

First Step—Incision of the skin, commencing at that part nearest the ring, and terminating about the middle of the hernial globe. Ligation or tortion of the superficial arterioles. These are the only vessels requiring compression during the operation. The section may be made with a bistoury, a scissors or cannulated sound, through the natural fibrous planes, or adventitious formations. We have now come in close contact with the sac.

OPERATION FOR THE RADICAL CURE OF HERNIA.

Such is the first step of the operation, and it presents nothing new in particulars. The operation has been done of that variety depicted in Plate 1, the patient lying in his bed; and and as we have examined him lately, we have seen that the hernia has not descended, as the dissection was very delicate.

In an adult, the finger in the ring very easily appreciates the fibrous resistance and the free, sliding movement of the serous surfaces, the one on the other. But with a child, whose tissues are young and without much resistance, this perception is evident, though imperfectly so, and must be sought for with great prudence, when the bare remnant of the sac may be outlined. When the abdomen is distended, on the other hand, the task is easy.

Second step of the operation—It consists in establishing a small opening into the sac. If the sac is greatly distended, gentle taxis will return part of the intestine. The tension of the pocket being less, it is now easy to pinch it between the fingers and make a small aperture, four or five millimetres in length, by which we may easily perceive the bare intestine.

The forceps serve to fix the borders, and mark the orifice which is enlarged by the fingers.

(To be continued.)

THE CARE OF THE PATIENT DURING THE LYING-IN PERIOD.*

BY MARGARET CALDWELL, M. D., WAUKESHEE, WIS.

That branch of the subject of obstetrics which I have chosen for my paper, "The Care of the Patient During the Lying-in Period," may seem too trivial with which to take up your time, especially as many physicians make no call after confinement, and a large number make but one. Both of these classes say, "Send for me if I am needed;" only the minority see the patient through the period of convalescence, which, in ordinary cases, is marked by the full complement of milk, a good appetite, the natural condition of the excretory organs, and later on, the proper position, etc., of the uterus. I am stating the subject as it has come under my own observation. If a labor is so free from complications that no call, or but one, is necessary after confinement, I think that patient would most likely be safer without a doctor; then there is no chance of carrying germs into the vagina during examination. The danger of infection in the two first stages of labor is great, when the temptation exists to pass the examining finger up between the head and the tender cervix, perhaps to confirm a former diagnosis of position, or without a purpose; the temptation is there, and very few, who are not experts, but will yield to it.

When the physician is called, if the patient's bowels have not moved since the commencement of labor, an enema should be given at once; then a bath—either a full, sitz, foot or sponge bath. If the necessary cleanliness of the body has been attended to, a foot bath will do more than drugs to relieve nervousness; it removes the nervous, nagging, irregular pains, which wear the patient out, and it facilitates labor in many ways. After the bath clothe the limbs in warm stockings and a comfortable undergarment, woolen preferred; there will not be so much danger from taking cold at the close of

*Read before the Wisconsin State Medical Society.

labor from the necessary exposure, and with one of Howard Kelley's abdominal pads, no stain is left upon bed or upper clothing, no changing afterward becoming necessary—only the removal from the lower limbs.

It seems to me that one great source of infection during labor is from allowing some of the enclosed air under the bed clothing to enter the vagina, possibly the uterus. Those cases are rare, but I have had a few where the vagina stood broad open for a certain period of time after the expulsion of the child. It is wise to anticipate this, by closing the vulva behind the child as it emerges from the parturient canal.

If, after proper antiseptic and aseptic procedure, with the uterus firm and of good size when grasped by the external hand, and an examination of the secundines shows that the membranes have been wholly expelled with the placenta intact, there is no need of further exploration, and the accoucheur need have no fear of sepsis from the uterus. This sounds like truth, but it is not. I had one case that deceived me. She developed high temperature on the third day, with all signs and symptoms of septic infection. An intra-uterine exploration revealed numerous elevations on the right posterior side, which could not be removed with the dull curette without danger of going through the uterine wall. Gentle scraping removed what seemed to be placental tissue. The scraping, followed by an antiseptic intra-uterine douche, would bring the temperature down to normal. I found it necessary to go through that routine, at first every day, then every other day for two weeks, when the uterine wall became smooth, and the septic symptoms did not return. This was her fourth confinement, in all of which I had attended her, and had no trouble before. She said she had had an abortion of two months previous to her last conception, for which she had had no doctor.

Was the debris the result of the abortion? She had her fifth confinement a few months since, which could not be improved upon. If the labor has been tedious, I give an aseptic vaginal douche; if complicated, making many examinations necessary, or the use of instruments, etc, I give an antiseptic douche. I am usually guided by the patient's feel-

ings about the continued use of the douche; always use it if the lochia is disagreeable, and once or twice daily, if it is soothing. It is wise to ascertain if the nurse in charge understands the meaning of the term.

Let me illustrate. A practitioner in Chicago told me that after giving to the husband, who was acting as nurse, the usual order, "Let me know if everything is not all right," left. In the course of a few days, the nurse called on the doctor to ask if the foul odor could not be stopped. He said, "Did you use the syringe I gave you?" "Oh! yes, doctor, and, although it does not affect the odor, it moves the bowels finely." Another case, which was under the care of a brother practitioner in the town in which I live. The doctor took a Davidson syringe, showed the intelligent (?) nurse how to use it in a basin of water, and left happy. Next day, not liking the appearance of the patient, he inquired, "Did you use the syringe?" "Yes, doctor, but the mixture you ordered was no sooner down, than it all came up again, and everything that had been eaten for a week." It is a fact that the nurse forced a pint of soap-suds down the patient's throat, by means of the syringe.

Repair all vulvar lacerations. It prevents many of the so-called uterine diseases, and the slightest tear where the cuticle and mucous membranes meet, may give rise to sepsis, by absorption of the lochia, and for a day or two, will be very distressing when the patient urinates. If any stitches are necessary, I have the douche given, when urination takes place. It dispenses with the use of the catheter, which is always a source of discomfort at best. A good sized piece of aseptic cotton, placed over the vulva, need be changed only when the patient urinates. Napkins placed over the cotton, may be changed as often as necessary for cleanliness, according to the amount of the flow. In ordinary cases, I allow the patient to decide about the abdominal bandage. I prefer it. I think it lessens the tendency to hemorrhage, cuts short after pains, and is a support to the patient. A napkin of four or five thicknesses, saturated with hot arnica or alcohol, placed under the bandage, is agreeable, and a good help in relieving after-pains; a sponge bath, with a little alcohol in the water, given

in the evening, is refreshing and conducive to sleep. The physician should not leave the house for at least an hour, if possible, after the completion of labor, or until the uterus is firmly contracted, and no danger of hemorrhage apparent. Let the patient have all the cold water to drink she wants, and give light foods till the mammary secretion is established.

The food during lactation, need be restricted only to those foods which are thoroughly digested by the mother; if they agree with the mother they will agree with the chlid. A bowl of gruel set by the bedside, and drank by the mother, when the child requires the breast during the night, will prevent that thirst and weariness which all nursing mothers complain of in the morning. A gentle purge should be given the second of third day; castor oil, I prefer. If its name could be changed, no patient would object to it, and no patient could detect its taste in a properly constructed mixture, the refining process has been brought so near perfection; but we all know it is more easily prescribed than accepted. The patient should not be dismissed until the physician has made a thorough examination, after sufficient time has elapsed for the generative organs to assume their natural condition, which is never less than six or eight weeks.

How many patients, when presenting themselves to a physician, say that they have not been well since a certain confinement, owing to cervical lacerations, sub-involution or some one of the many results which may arise after the most normal labor, and in the hands of a genuine expert. Each one of you, with a moment's thought, can call to mind a number of homes where the mother, who should be the life and sunshine of the domestic circle, is a constant sufferer, because some doctor did not see that she was all right, after passing through that fiery ordeal, which crowned her with the glorious title of motherhood, than which there is none greater this side of heaven.

CHILDREN AND DISEASE.*

BY G. E. MARTIN, M. D., CARTHAGE, SOUTH DAKOTA.

A subject in which we, as physicians, and especially those who are parents, and also those who expect to be, are deeply concerned about.

We find a great variety of symptoms in diseases of adults, but more especially in children do we have the same disease, showing more variety of symptoms and a greater range of extremes and endurance and inherited tendency to take on or throw off disease.

This is the time that diseased impressions are made upon the life that will show in future years, and gradually, yet victorious, (in most cases) sap the vitality of the future man or woman.

The remarkable peculiarities which all diseases assume in children, the results, the rapid changes from one of recovery to danger and *vice versa*, all make this study of children's diseases very important.

At first obscure and difficult of detection, these diseases quickly gain ground and intensity, and run, uncontrolled by any means within our reach. Or the disease may be progressing as well as can be expected, we may have assured the anxious parents that child was improving so far as you could see, when in a few hours you are summoned and arrive in time to see child in convulsions, to be relieved in death. Children endure colds and lung diseases better than indigestion and bowel diseases, showing the great responsibility and necessity of proper and nourishing food at all times.

On account of the nerve centers being very sensitive, they are easily impressed, inducing spasms or laying a foundation for future nerve disease. Here remedies and disease combat on equal grounds. In childhood, nursing and care do more than for adults. Nature is kind and will do more than for adults, showing a wise provision of the Creator in care of the helpless. We have to be on the alert and ever looking out for sudden changes and aggravated symptoms that are prone to occur

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and complications that are least looked for. We were sadly impressed with these hidden symptoms of disease in the death of our dear child, in March last, from that dreadful disease, scarlet fever; commencing and running mildly and progressing favorably in all respects, eruption and commencing to scale. Bidding me good-bye on leaving it at four o'clock in the morning, at eleven o'clock, on returning, I saw but too plainly strong symptoms of blood poison

Everything possible was done for him, calling two other physicians in council, but they could only tell what was only too plain. The great responsibility that we, as physicians, should feel in treating diseases of children, none can know but those who as parents have lost a dear child. While the world at large does not hold us as responsible in the treatment of children as adults, we should be held more responsible both financially and morally, because we have the care of one who cannot help itself, and the present and future health and success of the future for child and coming generations. The most responsible trust which we, as physicians, are given.

Here we find no fashionable sickness, no assumed or put-on symptoms. To be sure, we cannot depend on answers to your questions, neither are you mislead by false answers, as is often the case with adults.

You are placed more on your own resources for a correct diagnosis. Yet with close attention and study of all symptoms and expressions, such as the cry, position, countenance, and attentive physical examination, closely studying answers as given by mothers and attendants, we can form our diagnosis almost as correct as with adults.

In the treating of children's diseases, we find that medicine and remedies act with greater range and with less certainty than they do in adults. They have to be given more guarded and watched closer, and with the same diligence we have to watch the disease. In diseases of children, more depends on correct diagnosis than with adults, because often a disease is starting, that if allowed to run or progress, can only with long and persistent efforts be undone, and many are the mistakes that have been made. I will cite a few.

We attended an old lady, 72 years old, with slight cold, the

last month, who in her eight years had been blistered for two broken ribs, supposing it was her lungs. We know of a child treated for stomach trouble who had fallen from a load of hay and fractured the skull. My brother's child had been treated by four of the best physicians in Chicago, the past year, for rheumatism, hip joint disease, and tuberculosis, and among them was a specialist. (Here, let me say, is where the specialists make their greatest mistakes by incorrect diagnosis). The child, while jumping the rope, fell with his knee on a stone door sill, and after having knee opened and pus taken out five different times, and knee placed in a cast, is doing well.

Meigs, in Diseases of Children, states that a child does not secrete tears until third or fourth month. We have all attended cases where children have cried good big tears at birth.

I cite these cases to show the necessity of close and correct diagnosis, and that we can go by no rule except close and attentive study of each individual case at the bedside.

In treating diseases of children, that of most importance is to guard well and see that the food is of best and of sufficiently nourishing quality. We cannot attach too much importance to the food, not only in disease, but as a preventive of disease. And at this day and age parents need to be impressed more about the physical care and bringing up their children than the mental training, and brought to see the importance and necessity of a good sound body. The bright, good-looking, always clean child and smart little fellow is often simply living its life; while the slow and often indolent, always in the dirt, is storing up force and makes the active man of the future.

The small symptoms and little events are to be closely watched, for then is the time to prevent and do the most good in children's diseases. The surroundings and different ways of raising children and ways of living, are so various that the proper way to raise a child is a decided mystery, and we are often at a loss to know how to give best advice. For as we go from house to house and see children that have all that can be asked for, clothing, care and food, not stand diseases as well as one that has scarcely food to keep it alive, nor clothing enough to cover it, and poor at that; no fire in house all winter except in the rickety old cook

stove or burning hay or chips, with room so cold that we are cold with our wraps on. Yet we have seen these children go through severe cases of eruptive fevers and lung fevers better than the well-cared-for child with no difference in constitution or hereditary taint so far as could be seen. They are the first to be barefoot in spring; in fact a saying is, "you can't kill them." These facts partially show us the condition of children and diseases.

COMPOUND FRACTURE INFERIOR MAXILLARY—TREATMENT OF, ETC.

BY T. D. MCKOWN, M. D., CHICAMAUGA, GA.

The case that I will give you, is a man who, while driving a four-horse wagon, heavily loaded with trestle timber, fell off the wagon and was run over by the rear wheels. The load, I suppose, was easily 3,000 pounds, and the accident occurred while going down a steep rocky hill. I give these details in order that you may imagine the magnitude of the injuries sustained. The wheel passed over the right side of the head and face, crushing the left side into the rocks, it then passed over the left clavicle and left forearm. I was summoned at once and found following injuries:

Compound fracture superior maxillary, compound comminuted fracture inferior maxillary, fracture clavicle and first four ribs, compound fracture bones forearm. These fractures all occurred on the same side, which made them (to me) more difficult to treat. I will give the treatment of the fractures of maxillary bones in as few words as possible.

I cleansed the wounds and removed every particle of gravel, sand, etc. I then dressed the wounds antiseptically, and placed the broken bones in position, put on ordinary pasteboard splint and comprised it with the four-tail bandage. But the next day the broken ribs had made some injury to the lung, and my patient had a well marked case of circumscribed pneumonia with delirium. He would tear the bandages off and get the broken bones in worse shape than they were before they were placed in position. I could not rely

on the bandages of pasteboard for two reasons: First, I could not keep it in position; second, it interfered with the subsequent dressing of the wounds, for every time the splint is removed, the boxes will get "out of kilter," unless an assistant will hold the jaw fast, which entails an immense deal of suffering to the patient. To overcome those difficulties, I put a tight fitting plaster Paris splint that enveloped the whole jaw. This can be done very easily and effectually. I used a two-inch bandage, commencing at a point immediately under the chin, carrying the bandage around the top of the head (just missing the ear) and around the chin on opposite side. It should be carried around several times, and then commencing at syphysis menti, carrying bandage around nape of the neck and chin several times, then carrying the bandage up to a point just above the ear, running it around the occiput and forehead several times, fixing the splint firmly. I cut windows sufficiently large to allow drainage and dressing of external wounds. Suffice it to say, that patient did not pull this splint off. It has now been thirty days since he was hurt, and I am sure that the man will get well with little disfiguration.

Up to the present, I have extracted two very small pieces of bone, and believe there will be a number of them to come out before patient has complete union. It is possible that several months will have elapsed before he can use the jaw, but I believe I will get good union and a good jaw.

I shall use the plaster Paris splint in my next case, believing it to be the most rational way to treat all fractures of the superior maxillary. I am indebted to Dr. D. G. Elder for valuable assistance in fitting the splint.

THE HUMAN HEART.—The workings of the human heart have been computed by a celebrated physiologist, and he has demonstrated that it is equal to the lifting of 120 tons in twenty-four hours. Presuming that the blood is thrown out of the heart at each pulsation in the proportion of sixty-nine strokes per minute, and at the assumed force of nine feet, the mileage of the blood through the body might be taken at 207 yards per minute, 7 miles per hour, 168 miles per day, 61,320 miles per year, or 5,150,880 miles in a life time of eighty-four years. In the same period of time the heart must beat 2,869,776,000 times.—*Ex.*

Society Notes.

CLINICAL SOCIETY OF MARYLAND.

BALTIMORE, MD, May 6, 1892.

The 266th regular meeting was called to order by the President, Dr. Robt. W. Johnson.

DR. GEORGE H. EVERHART was elected to membership.

DR. HOWARD A. KELLEY introduced to the Society Dr. Weigert, of the Rotunda Hospital, Dublin. Dr. Weigert was invited to take part in the proceedings.

DR. H A. KELLEY then spoke on "Injuries to the Vaginal Outlet," illustrating his remarks by many beautifully prepared photographs, thrown upon a screen by a stereopticon. The photographs were all taken from cases under Dr. Kelley's care, both in Philadelphia and in the Johns Hopkins Hospital, Baltimore, and illustrated the operating room, normal vaginal outlets, injured outlets of different kinds, and the various steps in the operation for restoration. Dr. Kelley said in part: Injuries to the vaginal outlet are of three sorts: first, involving the *external anterior part of the perineum*, that is, the tissue from the fourchette, backwards towards the anus and upward towards the vagina. This is a superficial tear of no serious moment. The second form is the *complete tear* involving the whole of the recto-vaginal septum. Here the sphincter is ruptured, and as a consequence, the patient is unable to control her bowels or gases. The fact that a prolapsus is so rarely associated with this condition, shows that the perine body is not the supporting structure of the pelvic organs. The third form is the *internal tear*, that is, where the rupture lies in the right or left side of the vagina, or both, and can only be seen on drawing apart the labia, and lifting up the anterior wall with the speculum. This tear is concealed and is rarely seen. It is, however, from its frequency and its effect, the most important of all, for the result of such an injury is relaxation of the vaginal outlet. The rupture in the sulci extends down into the tissues, sepa-

rating the levator ani from its rectal attachments. The muscle is therefore no longer able to hold the rectum up under the pubic arch, the anus drops backwards, the vaginal walls roll out, and often without any external injury whatever, or even with an external perineum larger than normal, from the overstretching. Extensive eversion of the vagina, with decensus of the uterus, is one of the sequences of the inside tear.

The *operation* for such injury, is resection of the relaxation. There is no advantage in an operation that does not sacrifice any of the tissue; the best treatment is to take out of the relaxation just enough tissue to bring it back again to the normal size. It is not proper to confine this resection of the vaginal outlet to the exterior alone. The injury is more on the inside, and for this reason, the operation is also made to extend up the vagina, by making the denudation or resection in both the sulci and across the lower anterior face of the posterior vaginal wall. Two triangular areas of denudation point up both sulci; in these, the tissues on either side are loosely approximated by means of a single silk-worm gut suture to each sulcus. This is the tension suture. A number of cat-gut sutures are then able to do the work of approximation above this. (Cat-gut must never be used where there is much tension.) The lower part of the denudation is brought together by silk-worm gut sutures, passed in a transverse direction. An outlet thus restored, appears perfectly normal, or even virginal. If you were to examine such an outlet, a year or two after operation, you would say that the woman had an intact perineum.

DR. J. EDWIN MICHAEL agreed with Dr. Kelley, that the essence of this whole matter is the amount of damage inflicted upon the sphincter ani muscle. Sometimes a long perineum is a better indication of internal trouble than a torn perineum.

The operation referred to by Dr. Kelley, in which no tissue is lost, can hardly compare with the operation which Dr. Kelley practices; it cannot take up the broken ends of the sphincter, and tuck them up under the pubes, and that is what is wanted in these cases.

We are apt in these cases to do too much, and to make the vaginal outlet too narrow. The point on the labium, at which

the normal cleft ceases, is comparatively easily determined, and this enables us to give the proper size to the external opening; but in our internal denudations, we are inclined to do too much, and produce too great narrowing.

I recently attended a patient in labor, who had previously had a tear repaired by the method which has been explained by Dr. Kelley. The new-made perineum withstood the trial of a second labor, and is now about as good as before the labor occurred.

We ought to be thankful to Dr. Kelley for taking advantage of the circumstances with which he is surrounded, and illustrating the subject in this vivid way.

DR. J. H. BRANHAM: The tear of the levator ani muscle may sometimes be extensive without any laceration of the mucous membrane; and on the other hand, the mucous membrane may be extensively lacerated with very little laceration of the muscles. Nature of course, attempts to repair these damages, but the general practitioner, in allowing his patients to move about and sit up too soon, thus allowing pressure from above on the torn muscles, interferes with the efforts of nature. The condition should be recognized, and the patient kept long enough in bed to permit of thorough repair.

DR. HARRY FRIEDENWALD read a paper on "Cranial Deformity and Optic Nerve Atrophy."

DR. G. J. PRESTON thought the nerve atrophy was due to certain inflammatory conditions of the meninges and special pressure, and not due to general intracranial pressure.

The operation of linear craniectomy has not been a success thus far. The operation gives an opportunity for brain expansion, but very little. The damage has usually been done before the operation is undertaken.

DR. FRIEDENWALD: In cases of tumors of the brain, which are found far away from the anterior part of the brain, optic neuritis follows, and it is very hard to account for it, except on the theory of increased intracranial pressure, and my suggestion was, that in cases of marked cranial deformity, we are probably likely to have at some period a time when the intracranial pressure reaches the same height as it would in the case of intracranial tumor.

DR. I. E. ATKINSON narrated a case of rapidly growing intra-thoracic tumor, ending in death by suffocation in six weeks after first consulting his physician. The tumor, an aneurism of the innominate artery, was exhibited by Dr. K. B. Batchelor.

W. T. WATSON, Sec'y.

1519 N. Broadway, Baltimore.

IODIDE OF STRONTIUM.

(PARAF-JAVAL.)

In this salt of strontium, we have a remedy which advantageously replaces the iodide of potassium in the treatment of *cardiac affections.* Professor See finds that it is, for many reasons, far preferable to the alkaline iodides in these maladies. It does not cause gastralgia or palpitation; it slightly raises vascular pressure, and increases the respiratory functions, and its use does not determine acne or other skin phenomena. It possesses, also, an advantage in the fact that it is speedily eliminated by the kidneys. How far it may finally prove of value in the treatment of syphilis, can only be determined by rigid tests; but the fact that it may be used continuously for months, and in full therapeutic doses without giving rise to gastric disturbances, points to a great future for this salt in the direction cited. In asthma, chronic bronchitis, adenitis, scrofula, arthritis santurnism and hydrargyrism, it has already given remarkable results, as also in the long list of rheumatic and rheumatoid affections.

Dr. Laborde, in a communication to the Society of Biology, remarks that now that strontium salts are generally adopted in practice, he cannot too urgently insist on the necessity of their purity, if further accidents are to be avoided. Recalling his first contributions to the therapeutical uses of strontium, he stated that his physio ogical studies were made with absolutely pure salts, prepared specially by M. Paraf-Javal; these were also used to determine their clinical use, by Drs. G. See, Constantin Paul, Dujardin-Beaumetz, Bucquoy, Ch. Fere and others.

The authenticity of these pure salts, he looked on as an essential condition of success, and he considered it important to bring it to prominent notice.

Book Reviews.

A TREATISE ON GYNECOLOGY, MEDICAL AND SURGICAL.—By S. Pozzi, M. D., Adjunct Professor at the Faculty of Medicine, etc., Paris. Translated from the French edition under the supervision of, and with additions by, Brook H. Wells, M. D., Lecturer on Gynecology, New York Polyclinic, etc. Published in two volumes. Published by Wm. Wood & Co., New York. Sold by subscription.

VOL. II. contains 583 pages, 174 wood cuts and 9 full page colored plates. It treats of inflammations, cysts and neoplasms of uterine appendages and ligaments, genital tuberculosis, intra- and extra-peritoneal pelvic hematocele, extra-uterine pregnancy, diseases and injuries to vagina and vulva, malformation of the genital organs; with an addition by translator of two chapters on diseases of urinary tract, rectum and pelvis, taken from Auvard's "Traite Pratique de Gynecologie." Under oophoro-salpingitis, the author states that "he does not believe that true ovaritis exists without previous endometritis or salpingitis, that it is a mixed lesion; that inflammatory conditions of uterus are, without doubt, the chief cause of inflammations of the appendages," p. 7. Under cystic oophoro-salpingitis, pyo-hydro- and hemato-salpinx, are duly considered.

In treatment of acute salpingitis, he advises dilatation of cervix, curetting and iodine applications to endometrium. Does not consider electricity of much utility in diseases of appendages.

Forty pages are devoted to pathological anatomy of ovarian cysts, with one page to cysts of corpus luteum. Etiology, diagnosis, prognosis and treatment of ovarian cysts occupies 52 pages.

Chapter VIII. deals with solid tumors of ovaries.

Chapter IX. deals with tumors of Fallopian tubes, round and broad ligaments.

Chapter X. is devoted to tuberculosis, genital and peritoneal.

Chapter XI. considers intra- and extra-peritoneal pelvic hematocele.

Page 223, we find: "The effusion of blood into the pelvic cavity is probably quite frequent; there is no doubt that at the menstrual period the tubes are the seat of an exudation of blood as well as the uterus. Many menstrual disorders caused by fatigue, strain or cold, are really due to the effusion of a small amount of blood into peritoneal cavity, where it is rapidly absorbed." He also states that "hematocele is bi-lateral, that tubal pregnancy is not to be thought of, nor can we admit a reflux of blood from the abdomen into the tubes. The usual origin of extensive effusions of blood is undoubtedly the early rupture of an extra-uterine tubal pregnancy."

Chapter XII. is devoted to extra-uterine pregnancy.

Diseases and injuries of the vagina and vulva with malformation of the female genitalia, occupy a considerable part of the work. Diseases of the urinary tract, rectum and pelvis are disposed of in two chapters, which are translated from Auvard's recent work.

The two volumes are a valuable contribution to the gynecological literature of the day. The translator has done his work well, while the plates and binding are well executed.

R. R. K.

A NEW PRONOUNCING DICTIONARY OF MEDICINE.—By John M. Keating, M. D., LL. D, and Henry Hamilton, with the collaboration of J. Chalmers DaCosta, M. D., and Frederick A. Packard, M. D. Published by W. B. Saunders, Philadelphia, 1892. Price: cloth, $5.00 net; sheep, $6.00 net.

THE publication of this work, since its announcement, has been awaited with no small degree of anxious expectation. It is a voluminous and exhaustive hand-book of medical and scientific terminology, with phonetic pronunciation, accentuation, etymology, etc., with an appendix containing important tables of bacilli, micrococci, leucomaines, ptomaines; drugs and materials used in antiseptic surgery; poisons and their antidotes; weights and measures; thermometric scales; new officinal and unofficinal drugs. So thorough has been the work of its authors, that it is but just to say that it reflects great credit both upon themselves and the publisher, and that it will be found a valuable and indispensable aid to the physician.

C. E. J.

MANUAL OF SKIN DISEASES.—With special reference to diagnosis and treatment, for the use of students and general practitioners. By W. A. Hardaway, M. D, Professor of Skin Diseases, in the Missouri Medical College and in the St. Louis Post-Graduate School of Medicine; Dermatologist to the Augusta Free Hospital for Children; Consulting Dermatologist to the City, and Female Hospitals, etc. Published by Lea Brothers & Co., Philadelphia, Pa.

PROFESSOR W. A. HARDAWAY has written a very condensed, instructive, and admirably arranged treatise on the Diseases of the Skin. His style and descriptions are good, and though in some instances he might elaborate, yet for the rushing student and busy practitioner much knowledge can be obtained. His appendices are quite in good taste and handy as references, for many of us are at times in need of a good suggestion as to a formula, when ours have failed to do the work, and here good ones can be found with the minimum exertion. We take pleasure in recommending this volume.

H. H.

ESSENTIALS OF PHYSICS.—Arranged in the form of questions and answers. Prepared especially for students of medicine, by Fred. J. Brockway, M. D., Assistant Demonstrator of Anatomy at the College of Physicians and Surgeons, New York. Published by W. B. Saunders, Philadelphia, Pa.

IS A VERY modest and highly instructive treatise on physics, and is, as its name implies, most admirably adapted to medical students. Though this little book does not aspire to the dignity of an exhaustive dissertation on physics, it will be found full of merit and worth, though modest. The price of $1.00 is cheap, and any one, whether medical student or not, will do well to read it.

H. H.

A PRACTICAL MANUAL OF DISEASES OF THE SKIN.—By George H. Rohe, M. D., Professor of Materia Medica, Therapeutics and Hygiene, and formerly Professor of Dermatology in the College of Physicians and Surgeons, Baltimore, etc. Assisted by J. Williams Lord, A. B., M. D., Lecturer on Dermatology, etc., in the College of Physicians and Surgeons, Baltimore, etc. Published by the F. A. Davis Co., Philadelphia, Pa.

THIS little work of Dr. Rohe's is very creditable, and contains much that is valuable. The medicamentation mentioned throughout the book is very fine, and his classification and pathology good.

H. H.

ESSENTIALS OF MEDICAL ELECTRICITY.—By D. D. Stewart, M. D., and E. S. Lawrence, M. D., Philadelphia. W. B. Saunders, 913 Walnut St., Philadelphia.

THE first line of preface states, "the writers of this manual lay no claim to originality." The competitive labor to present to the student, "a general idea of the diagnostic and therapeutic value of electricity." In this they have succeeded, and to those who are interested in the subject, this monogram will prove of value. A small book, neatly and substantially bound, contains 158 pages. There are a number of cuts, illustrations of instruments, and therapeutic application of electricity. The price is $1.00. The authors are experienced teachers in the Jefferson Medical College. A. B. P.

COCAINE IN HAY FEVER.—Regarding the use of cocaine in hay fever, Dr. George F. Keifer, of Lafayette, writes the *Journal* as follows:

The hay fever season is upon us. A common prescription reads thus: Cocaine muriate, ten grains; water, one half ounce. Spray as necessary to control paroxysms.

Cocaine is used thus because it produces relief, and for no other reason. I wish to enter an unqualified objection to any prescription made thus, calling for the use of cocaine *ad libitum.*

Cocaine is an admirable anesthetic. One of its actions is the contraction of mucous membranes with which it comes in contact. For the action of cocaine upon mucous membranes there is the reaction of relaxation of mucous membranes. Let that relaxation be produced repeatedly, and it is soon a chronic relaxation which I have found in a number of instances to be polypoid in character. Bosworth writes that the primary lesion, probably in most cases, is the obstruction, as shown by Harrison Allen. Why make the nasal obstruction worse? The rational treatment is to get rid of that obstruction, according to the general principles of surgical practice. Moreover, I have seen several cases where the patient was made a total wreck by the formation of the cocaine habit.—*Indiana Medical Journal.*

Selections and Abstracts.

PAPOID IN GASTRO-INTESTINAL DISORDERS.*

BY DR. FRANK WOODBURY.

During the past year, having devoted considerable attention to the clinical application of papoid, especially in digestive disorders, I have had the satisfaction of witnessing a number of very interesting results, to which I wish briefly to direct attention. The successful application of physiological data must be my excuse for again directing attention to a remedy which has been studied by such eminent investigators as Wurtz, Bouchut, Finckler, Rossbach, Roy and Wittmach, and one furthermore, the physiological and therapeutical actions of which may be regarded as pretty fully established. I point out very briefly some of the clinical uses and the conditions of its successful employment.

The physiological actions of papoid as a digestive agent have been thoroughly established. It acts upon albuminoids, hydrating and converting them into peptones, as fully demonstrated by Herschell. It converts starch with great promptness, the ultimate product being maltose. It emulsifies fats. Herschell declares that it has a direct tonic action on the stomach, stimulates the secretion of gastric juice or pepsinogen. It acts at all temperatures, but attains its maxim activity at about 130 deg. F. In several important points it differs from pepsin. Papoid acts best in an alkaline solution, but also can act in fluids with an acid or neutral reaction. Pepsin requires an acid solution. Papoid is freely soluble and is most active when in concentrated form. Pepsin requires free dilution. Herschell also points out the greater digestive power possessed by papoid than either pepsin or pancreatine, and states "that it can be used when pepsin is contra-indicated or powerless." Papoid has no action upon living tissues, and is positively innocuous when swallowed in any

*Extract from article in *New York Medical Journal*, of July 30th.

quantity that is likely to be administered. Papoid is useful when digestion has been overtaxed, or when the secretion of gastric juice is absent or deficient. Experiments of my own and others have satisfied my mind of the remarkable digestive activity of papoid. In one of the experiments referred to, the constituents of a hearty dinner of bread, meat, potatoes, peas, mince-pie, and other substantials were placed in a test tube and treated with papoid and bicarbonate of sodium and a small amount of water. The result was very satisfactory indeed; the meat rapidly softened, and the other ingredients gradually disintegrated, forming a pultaceous mass, which finally separated into a grumous sediment and an overlying, albuminous, dark colored liquid. Papoid acts in an alkaline solution even better than in acid media. It is evident that it is specially useful where there is indigestion due to deficient secretion of gastric juice. In such cases, the administration of an alkaline solution of papoid favors gastric digestion, both directly and indirectly: First by digesting albuminates and softening masses of food. Secondly, by the action of the papoid in stimulating the secretion of the pepsin gland. It retards the fermentation of the undigested masses of food in the stomach, and prepares them for intestinal digestion. In the contrary case where the stomach contents poured into the duodenum are so acid that they prevent the action of the trypsin. Papoid prevents duodenal indigestion by taking the place of the pancreatic ferment. As Herschell says, it is obviously of no use to give pancreatine by the mouth, as it is at once destroyed by the acid of the stomach, and it is practically impossible to administer sufficient alkali to neutralize the excess of acid, and it would moreover be unwise, because it would stimulate still further the secretion of the acid. Papoid is of the greatest use here. In gastralgia, which often accompanies the condition just named, papoid with bi-carbonate of sodium gives immediate relief. It is also useful in irritable stomach, nausea and vomiting. In gastric catarrh, and the catarrhal conditions of the intestinal tract, popularly known as biliousness, papoid administered in hot water fifteen minutes before meals, cleanses off the mucus and places the mucous coat of the digestive or-

gans in a good condition for secretion. It is useful in the treatment of irritative diarrhœa in young children, to whom it may be given in combination with salol or salicylate of bismuth. The use of papoid in treating disorders of the digestive organs may be summarized somewhat as follows:

1. In actual or relative deficiency of the gastric juice, or its constituents. (*a*) Diminished secretion of gastric juice as a whole. Apepsia; anæmia and deficient blood supply, wasting diseases. (*b*) Diminished proportion of pepsin; atonic dyspepsia, atrophy of the gastric tubules. (*c*) Dimunition of hydrochloric acid; achlorhydria, carcinoma. (*d*) Relative deficiency of gastric juice; overfeeding.

2. In gastric catarrh. (*a*) Where there is a tenacious mucus to be removed, thus enabling the food to come in contact with the mucous membrane. (*b*) Where there is impaired digestion.

3. In excessive secretion of acid. To prevent duodenal dyspepsia.

4. In gastralgia, irritable stomach, nausea or vomiting.

5. In intestinal disorders. (*a*) In constipation due to indigestion. (*b*) In diarrhœa, as a sedative. (*c*) In intestinal worms. (This claim the writer has not personally verified, but as the intestinal mucus, which shields the worms is removed by papoid, it is easily understood that their removal would naturally result after its administration.)

6. In infectious disorders of the intestinal tract. (*a*) Where there is abnormal fermentation by its antiseptic action which may be heightened by combination. (*b*) Where there are foreign substances present, its detergent effect may be utilized by cleaning out the debris from the intestinal contents by digestion.

7. In infantile indigestion; here papoid not only readily peptonizes cow's milk, but the resulting curds are also soft and flocculent, resembling those of breast milk.

The dose of papoid ordinarily, is one or two grains, but five grains or more may be used, the only objection being that of useless expense and waste, except where very prompt effects are desired.

SUBSTITUTION AND ITS ATTENDANT EVILS.

BY JOHN AULDE, M. D., PHILADELPHIA, PA.

The evils attendant upon substitution and sophistication of remedial agents, have long been surmised; they have not, however, until recently, received attention at the hands of the medical profession. Increased diagnostic skill, along with greatly improved facilities for the manufacture of medicaments, favor an approach toward mathematical exactness in computing therapeutic results. When these are wanting, we challenge the character of the remedy. The question which presents itself is: Has our patient received the true medicament, or a base counterfeit? However attractive in theory, it will be found impracticable for the medical profession to drift away from the pharmacists, and it should be our aim to reward the faithful and bring the guilty to punishment. The friendly bond between the two professions should be honesty, as neither can afford to work independently; there is an interdependence which makes them mutually helpful.

It is said of Lawson Tait, that he has returned to first principles, and carries a mill with him, so that when ergot is needed, he prepares it fresh with his own hand. The reliable character of Squibb's ether has been maintained through his business sagacity, in having it prepared chemically pure and distributed all over the world in sealed cans, thus precluding the possibility of sophistication or substitution.

The life of a patient suffering from rheumatism may depend upon his being supplied with sodium salicylate prepared by a combination of Merck's chemically pure bicarbonate of soda, and true salicylic acid obtained from oil of wintergreen, and yet, few pharmacists even in large cities, pretend to keep either in stock. They are the exception in Philadelphia, and doubtless the same is true of other cities.

Some years ago, Dr. Squibb, of Brooklyn, set his seal on Marchand's peroxide of hydrogen, by endorsing its character and defending its merits as the most powerful and yet harmless bactericide which could be employed in the treatment of

various formidable and fatal diseases. Dr. Robert T. Morris, Dr. Paul Gibier and other well known authorities have corroborated his statements from clinical observation, and as a consequence, a revolution has taken place in our methods of treatment in both medical and surgical practice. The efficacy of this simple remedy, its innocuousness and extended field of application, have shed a flood of light upon modern therapeutics, but at the same time, there has followed in its train, a host of worthless imitations.

The substitution of the commercial for the medicinal peroxide, is calculated to work serious injury, and destroy our confidence in a most potent remedy. In the treatment of diphtheria, for instance, the commercial product is positively harmful. When death results, shall we blame the attending physician or the unscrupulous druggist who substitutes a base imitation for the genuine product? And still, pharmacists who claim to be respectable, do not hesitate to trifle thus with human life. Is it any wonder then, that our mortality percentages are on the wrong side?

Cascara sagrada has been counterfeited and sophisticated, until it is almost impossible to secure a reliable preparation of this most useful medicament, although Parke, Davis & Co., the pioneers in its introduction, have adopted every means in their power for the protection of the medical profession.

Antipyrin, a patented preparation, has met with phenomenal sales, and possesses distinct therapeutic properties, and as a result, imitations and substitutes are offered to take its place in medical practice. Whether these imitations are better or worse than the original product, I do not care to discuss; neither is it for the druggist to decide. The decision here, as to any special remedy or preparation, rests entirely with the physician, as he alone is responsible for the condition of the patient; no one else, not even the druggist, should be permitted to interfere with his directions. Substitution is an evil which should be guarded against; it is an evil which must be eradicated or the entire medical structure will collapse. It is a duty we owe to ourselves and to our patients, to look after this unnatural condition of affairs in which we are so vitally interested, and the time is near at

hand when a systematic effort must be made, with a view to accomplish the desired end.

This subject is commended to the attention of the American Medical Association, with the suggestion that a committee be appointed who who shall recommend suitable measures for the protection of the medical profession against the evils of substitution and sophistication on the part of unscrupulous pharmacists. Shall we have a "list"?—*Journal of the American Medical Association.*

REPLY TO "ENLARGED PROSTATE A MYTH."

I notice in the April number (*Medical World*, page 131,) an article by J. C. Campbell, M. D., speaking rather disparagingly of the attention given to the subject of enlarged prostate, and exhorting physicians to pay more attention to "contractions and soreness of the urethra." I do not think there can be too much attention given to that most distressing and often fatal disease of the prostate gland and appendages; two fatal cases having come under my observation within a year, reminding me most forcibly of what may eventually be the means of my "taking off." It is true, that whereas I was once "youug, but now am old" (nearly 80), yet never have I suffered my urethra to be impaired by the means he would have us believe. I am convinced that this affliction, diseased prostate, is much more prevalent than he would intimate, if I may j dge from the inquiries from physicians, that my article on the subject (Jan., 1891,) called forth; no less than fifteen having written of their own cases. If the people throughout the country are afflicted in the same proportion, there must be a great many suffering with it.

The "urethral contractions and soreness" he advises us to examine, are very simple ailments and easily treated, compared with a real enlarged prostate, a fact that I think he would duly appreciate if he happened to be a subject of that "*enlarged prostate rut*" he speaks of.

Now, Mr. Editor, it may appear egotistic in me to further encroach on your space or patience, in reference to my own case; but as I have already given your readers something of

my experience up to Jan., 1891, I venture to obtrude still further, though the subject may be hackneyed.

In that article (Jan., 1891,) I brought saw palmetto into notice as having helped me more than anything else I ever tried, and felt very hopeful of its lasting effect, and can now say, that its action on the gland has been effective in preventing further enlargement, but it failed to relieve, except temporarily, irritation of the neck of the bladder and prostatic portion of the urethra; so I had to use the catheter occasionally.

Some four months ago, my attention was called to a new remedy called "sanmetto," composed of saw palmetto and santal. As a drowning man will "grasp at straws," so I grasped at a bottle of the remedy, and have been using it for about three months with great relief, for I have no use for the catheter now, and the deposit of mucus, instead of being an inch or more thick in a quinine bottle of urine, as formerly, is now nearly *nil*, and no pain or irritation in urinating. I think the combination of saw palmetto and santal is a happy idea—the former acting on the gland, and the latter on the mucous membrane of the bladder and urethra.

It may lose its effect as other things have, but it commends itself to my judgment as covering the pathological conditions better than any other remedy I have tried. For the benefit of those who have written me on the subject, I can say it is pleasant to take the dose, a teaspoonful about three times a day.

H. KNAPP, M. D.,
In July Medical World.

Lathrop, Cal.

ON THE DIAGNOSTIC AND PROGNOSTIC VALUE OF TENDON REFLEXES.

BY JOHN FURGUSON, M. A., M. D. (TOR.), L. R. C. P. (EDIN.).

The physiology of the tendon reflexes is a matter of much dispute. Some maintain that they are of a reflex character and of spinal origin, while on the other hand, equally competent observers consider that they are due to a mechanical excitation of the muscle, such as a blow upon its tendon.

But there is not such a great difference between these views, when both agree that the state of muscular irritability which causes the muscle to respond to excitation, is due to a nerve-stimulus supplied to it from the spinal cord. The writer believes that the tone of the muscle is due to its normal and healthy connection with the spinal centre; and this latter receives its stimulus from the cerebellum, the cerebellar influx, and is held in check by the cerebrum, the cerebral inhibition. Derangement of this mechanism would result in either a deficiency, an exaggeration, or an abolition of the reflexes.

When the control of the cerebrum is removed by the occurrence of a hemorrhage, the growth of a tumor, the existence of a degeneration, or an epileptic paroxysm, the muscular irritability increases, and the tendon reflexes are exaggerated. In cases of cerebral hemorrhage, the tendon reflexes may be enfeebled or abolished, provided the apoplexy was of sudden origin. No special prognostic value can be attached to the absence of the deep reflexes in such cases, as the real causes of the abolition of the tendon reflexes are the position and the suddenness of the hemorrhage rather than its extensive character. In the great majority of cases of cerebral hemorrhage, the reflexes soon return. If there is any pressure on the cerebellum, however, the reflexes will not return as long as this pressure lasts. In cases of cerebellar tumor, the knee-jerk is usually wanting, and cerebellar titubation may be present.

In cases of injury to the spinal cord where the reflexes are absent after a lapse of several weeks, the prognosis is very grave, as the indications are that the cord lesion is a very serious one. In all diseases or injuries of the motor areas of the brain, causing a loss of control over the spinal cord; in all injuries and diseases of the motor paths, capsular, crustal, or pyramidal, by which the influence of the cerebral cortex is cut off from the spinal centres, there is developed a condition of extreme excitability of the reflexes. Such conditions as spastic paralysis following some lesion in the motor tracts, primary spastic paraplegia, cerebral spastic paralysis of children, the ataxic paraplegia of Gowers, and multilocular

sclerosis, are all conditions in which we meet with an exaggerated condition of tendon reflexes. The sooner the knee-jerk becomes increased in these cases, and the greater the degree of this increase, the worse must the prognosis be. After a careful study of a number of cases of general paresis, the writer concludes:

1. When the knee-jerk is little affected, the disease in the cerebrum is not very extensive; and the more rapidly the disease increases, the more rapid will be the increase in the knee-jerk.

2. When the knee-jerk is reduced or lost, there is coincident disease in the spinal cord, either of the postero-external columns, or of the anterior cornua.

3. If the disease be in the posterior columns, there will be symptoms pointing to this, as found in tabes dorsalis.

4. When the cord disease is in the anterior cornua, along with the loss of the knee-jerk, there will be a flaccidity, atrophy, and degeneration of the muscles.

5. The loss of the knee-jerk, due to either of these morbid changes, would call for a very unfavorable prognosis, and would preclude much hope of even a temporary arrest of the disease.—*Medical Record*, New York.

THE MEDICAL AND SURGICAL REGISTER OF THE UNITED STATES.—R. L. Polk & Co., Detroit, Mich., have now in course of compilation the third edition of this valuable publication. The Medical and Surgical Register has become a standard work and occupies its field exclusively; it gives a complete record of the physicians of the United States, colleges and date of graduation, besides much other valuable information of interest to the profession. It is the only work that has ever made the attempt to record the physicians of the United States according to the medical college training each individual has received, and is remarkably free from the mistakes inseparably connected with the preparation of such a volume. The work is worthy the support of the profession, and we trust that every physician will respond promptly to the request of the publishers for data which will aid materially the compilation of the work.

HOT BLANKET PACKS IN THE TREATMENT OF FEVERS.

(*New York Medical Journal*, May 28, 1892, p. 606) Dr. W. W. Bremner describes in detail his method of reducing temperature in the treatment of typhoid fever and other febrile diseases. He employs a blanket just large enough to completely envelope the patient, folded lengthwise twice and then rolled up into a moderately tight roll. A boiling solution of soap, made by dissolving two ounces of good soap in two quarts of water, is then poured slowly into the centre of each end of the roll of blanket, so as to thoroughly saturate it. A bed is then prepared by covering it with a Mackintosh sheet, over which is laid a large, dry, double blanket. The patient should be undressed and have a loose blanket thrown over him until he can be enveloped in the hot blanket and the dry one wrapped around him. The arms are enclosed on both sides, first with a wet blanket, and then with a double dry one, care being taken to make the latter fit closely around the neck. If the feet are cold, a hot-water bottle should be applied to them. The pack should be continued from one to two hours, according to the state of temperature and the feelings of the patient. Children often fall asleep during the application, and seem rather to enjoy the procedure. After the blankets are removed, the patient should be gently rubbed with a soft towel and replaced in the ordinary bed. The pack may be repeated two or three times a day, or as often as necessary until the temperature remains permanently below the danger point. Cold applications may be made to the head, and the patient may be supplied with cold water to drink as often as he wishes. The writer believes that this method of treatment has all the advantages of cold water applications without any of their drawbacks, and that the temperature can be lowered by a process of evaporation in this way just as certainly as by the use of cold water, so highly recommended by the followers of Brandt.—*Inter. Med. Mag.*

TOPICAL TREATMENT OF PARENCHYMATOUS KERATITIS AND CORNEAL OPACITIES WITH MERCURIAL OINTMENT.—J. Mitvalsky, M. D. (*Merck's Bulletin*, May, 1892,) writes of the treatment of parenchymatous keratitis and corneal opacities with a diluted mercurial ointment. The formula he uses is:

Mercurial ointment (33 per cent.),.....1 part.
Vaseline,..... .....2 parts.
Lanolin,.....1 part.

He finds the greatest amount of good result from the use of the ointment in parenchymatous keratitis in the very first stages of infiltration. The application of the ointment causes a prompt absorption of the products of infiltration in most cases without a typical vascular stage developing. If there is much pericorneal injection, brow-ache, or photophobia, the ointment is contra-indicated. Good results are obtained only when the inflammation is accompanied by irritation or very mild symptoms of ciliary irritation. When the inflammatory process is declining, the ointment is valuable. In clearing up old corneal opacities, he regards the ointment as superior to any agent we possess.

TREATMENT OF TYPHOID FEVER.—In a paper read before the Florida Medical Association (*Transactions*, 1892,) Dr. Warren E. Anderson, of Pensacola, states his belief that typhoid fever being a self-limiting disease, attempts to abort it are injurious. He cautiously administers, with most gratifying results, minute doses of calomel throughout the entire course of cases. Its antiseptic properties prevent rapid decomposition of the ingesta; while its stimulating effect upon the kidneys and glandular system hastens the elimination of the poison from the system. He thinks oil of turpentine superior to salol, hydro-naphthol, etc., as an intestinal antiseptic—the most delicate stomach soon acquiring a tolerance of it. Quinine is of unquestionable value, but do not keep the patient cinchonized. *Do not resort to antipyretics* until the temperature rises above 102 degs. F. Where an antipyretic is required, he prefers antikamnia Cold water sponging of the neck, face and upper extremities is grateful to many patients. In the ten recent cases in which he has used hot-water

enemata, flushing the colon, he has been more than pleased with the results. He has been repaid by allowing copious draughts of water—not warm until convalescence, nutrition should consist of boiled milk, with freshly expressed juice of beef.

Dr. Joseph D. Rush, of Apalachicola, Fla., (*Idem*) reports favorably on the value of salol in typhoid fever. He details two cases. One, a married lady, brunette, age 24 years, with fever reaching 105 degs. F. by the seventh day, after the failure of calomel, soda and quinia, was given the following:

R. Salol.
Antikamnia.....aa dr. ss.
Quiniæ sulph.....gr. vj.
Mix. Make twelve capsules. Sig. One every three hours.

This prescription was kept up twelve days, when convalescence began. Alcoholic baths to the spinal column were given once a day. Diet was strictly boiled milk and beef tea.

The other case was that of a colored boy, age 13 years, temperature 105 deg. Same prescription, sponging and diet as above. Recovered. His conclusions are that salol as an internal antiseptic, with daily sponging of the body with alcohol, and with a diet of hot boiled milk, promises much in the treatment of low and continued fevers, with bowel complications.—*Virginia Medical Monthly.*

ETIOLOGY AND PATHOLOGY OF DYSENTERY.*—We can divide dysentery into three forms: 1. Diphtheritic; 2. Catarrhal; 3 Amœbic.

Diphtheritic dysentery is characterized by necrosis of the epithelium and a fibrinous exudation. It is the form usually met with in acute epidemics. It may also appear in the course of a number of diseases, and may be produced by a number of causes. There is nothing in the anatomical lesions by which we may distinguish the action of a definite pathogenetic agent.

Catarrhal dysentery is characterized by an inflammation of the mucous surface of the intestine, leading to the produc-

*From a paper read before the American Association of Physicians, Washington, D. C., May, 1892.—*The American Thelapist.*

tion of shallow ulcers. Affections of the lymph follicles are more common in the catarrhal than in the other forms. What is said of the croupous is also the case in the catarrhal. In both these forms abscess of the liver may appear, but it is very rare.

Amœbic dysentery is characterized by definite lesions in the large intestine and elsewhere. The lesions have always the same character, and we can recognize in them the action of a common agent There are extensive ulcerations of the intestines, which, contrary to those of the other two forms, appear to be produced, not by extension downwards from the surface, but by a primary infiltration of the submucosa, with subsequent destruction of the overlying mucous membrane. Clinically, the disease is characterized by remissions and great chronicity. Abscess of the liver and lung is more frequent in amœbic dysentery. The disease is caused by the amœba dysentericæ, and is associated with most of the cases of tropical dysentery.—W. T. COUNCILMAN, M. D.

APPENDICITIS—ITS DIAGNOSIS, PATHOLOGY, AND TREATMENT.

(*New Albany Medical Herald*, May, 1892, p. 435.) Dr. L. S. McMurtry gives a brief *resume* of this subject. Appendicitis, in the writer's opinion, is the most frequent of all the causes of peritonitis in the male and a frequent cause of the same in the female. This inflammation may vary from the simple catarrhal form with infiltration of the sub-mucous tissues to perforation and complete gangrene of the part. The course of the case may be acute, sub-acute or chronic, giving a clinical history which may be characterized as fulminant, explosive, recurrent, or mild. In diagnosticating appendicitis, it is impossible to give an accurate estimate of the extent and severity of the lesions. Sometimes the condition may be mistaken for simple intestinal disturbance and passed by unnoticed. On the other hand, cases which may be quite severe and characterized by pain, tenderness, swelling, and febrile action may yet terminate in resolution and complete recovery. In the latter class, inflammation is very apt to

recur. Whether it is best to operate, should be determined more by the grade of inflammation than by the time it has existed. "When a diagnosis has been made and three days have elapsed without diminished pulse-rate and temperature, operation should be done." The writer believes that operation involves less danger than delay, and should be resorted to in all cases in which a high grade of inflammation is persistent.

EMPLOYMENT OF HYDRASTININ IN UTERINE HEMORRHAGES.—(*Archives of Gynecology*, May, 1892)—Dr. Emanuel reports the use of hydrastinin hydrochlorate in forty-eight cases in Czempin's clinic in Berlin, three-eighths of a grain being given in gelatin capsules three or four times a day after the hemorrhage had begun, with the following results: twenty-six of the forty-eight were so influenced by the remedy that the bleeding ceased in the succeeding twenty-four to thirty-six hours, a result which has not been obtained by any other known remedies. Hydrastinin seems to act on the small vessels of the mucosa, whereas ergot exerts its influence upon the smooth muscular fibre. Hence the former does not take the place of ergot in *post-partum* hemorrhages or hemorrhages after abortion. No disagreeable symptoms were observed from the employment of hydrastinin.—*Ex.*

ANTIDOTE FOR CARBOLIC ACID.—It is now reported that an efficient antidote for poisoning by carbolic acid has been discovered by an Italian tailor, who swallowed by mistake thirty grammes of carbolic acid. Dr. Morett, of Ancona, using a rubber sound, immediately introduced by slow degrees into the patient's stomach a strong solution of sulphate of soda, which forms with carbolic acid a harmless mixture. In an hour's time the patient, who had been in a most critical condition, began to revive, the pulse became better and the respiration improved. Inhalations of ammonia were then used to hasten up the process, and little by little the poisoned man rallied so much that an emetic, followed by a dose of lime water, finished the cure.—*Ex.*

THE TREATMENT OF ERYSIPELAS.—(*Therapeutic Gazette*. April, 1892.) In an editorial article, the writer states that in his experience, the treatment which has yielded the best results, consists in washing the part which is affected with a solution of bichloride of mercury in the strength of one to ten thousand, and then thoroughly annointing the skin with an ointment of ichthyol, two drachms to the ounce of lanolin or benzoated lard. This is applied freely, and the part protected by a layer of salicylated cotton and a gauze covering. This treatment, it is claimed, produces a rapid limitation and subsidence of the disease. In addition, however, full doses of the tincture of the chloride of iron should be given and repeated somewhat frequently. In connection with these remarks, the following conclusions reached by Klein, of Warsaw, are given:

1. Ichthyol undoubtedly checks the progress of the disease, either by its reducing action on the tissues, or by its direct action on the micro-organism, or by both actions simultaneously.
2. Ichthyol shortens the mean course of the disease, by about one-half.
3. The treatment is continued from three to four days.
4. The course is considerably milder when ichthyol treatment is employed.

ON THE USE OF COCAINE IN GENITAL IRRITATION IN MEN.—(*Therapeutic Gazette*, May, 1892.) By H. Wells, M. D. The writer gives a series of cases in which genital irritation in men was much relieved by the injection of about half a drachm of a four per cent. solution of cocaine into the posterior urethra. He recommends the application of the solution locally, in cases of irritation of the glans or prepuce in growing boys, and in the nocturnal incontinence of urine sometimes dependent on such irritation. The effect, according to the writer, lasts for some time. He was led to this use of the drug by noticing that, after the free use of cocaine in nasal and pharyngeal catarrh on all occasions, when he was able to examine it, the penis was much retracted and there was a decided reduction in the sensitiveness of the glans.—*Ex.*

Editorial.

MEDICAL COLLEGES AND MEDICAL EDUCATION IN THE SOUTH.

Three of our Southern medical journals, *The Virginia Medical Monthly* of July, the *Atlanta Medical and Surgical Journal* of August, and the *Alabama Medical and Surgical Age* of August, contain editorials on this subject; the former, in all spirit of fairness, and the two latter in a *decided* spirit of unfairness. I say the two latter, but probably it would be better to say the *Atlanta Medical and Surgical Journal* alone, for the editorial in the *Alabama Medical and Surgical Age*, with the exception of a paragraph at the beginning, and one at the ending, is copied from the *Atlanta Medical and Surgical Journal;* and strange to say, both journals are *August* numbers. So, with the exception of the copied editorial and the credit it claims of having first published "the unique table given in his annual address of the medical colleges in this country, and the medical examining board of Alabama, by Dr. B. J. Baldwin," they can be put aside.

* * *

Now, before taking up the editorials for review of the other journals, we have a word to say in defense of the Southern colleges, and the work they have accomplished. For we know that medical education in the South is not at the low ebb the editorial in the *Atlanta Medical and Surgical Journal* would have us believe.

The Southern colleges have graduated men capable of doing as good, honest, conscientious work—as brilliant work—as any in this country. No part of the world has produced as many pioneers in the advancement of the medical sciences in proportion to their numbers as the South, whose achievements have done more to alleviate the sufferings of humanity than any others. It would be useless to cite illustrations, for they are known to all who are familiar with medical progress.

* * *

The older colleges of the South have progressed under great disadvantages; they were torn up and used for the reception of our wounded during the war. After this cloud had passed away, and the professors who were so fortunate as to survive their active service in the front had returned, they began to re-organize. Sadly the faculties met, and with sorrow, filled the vacancies caused by the death of those poor fellows who had given up their lives in the defense of that which they loved so well.

Immediately they went to work, and nobly and successfully did they strive to refit their dismantled schools; going into their own pockets for funds. For, as many of the older physicians can testify, they frequently graduated men who have since become distinguished, who, at that time, did not have money enough to pay their matriculation fees, taking the notes of the poor fellows rendered destitute by no fault of theirs except the love of their country, depending simply upon their honor for them to be redeemed, should they ever become able to do so. I am glad to say these honest, hard-working physicians have almost invariably redeemed their pledges, where they have not passed away with the ebbing tide before it was possible.

This action of the colleges was a necessity, for nearly all the schools had been closed during the whole period of the war. Nearly all the physicians enlisted in active service, and went to the front; but many, many of the poor fellows never returned. So that, in many vicinities, physicians were absolutely necessary.

And to-day, may it be said to their shame, many of the younger generation point to the noble institutions to whom the South owe so much, with a finger of scorn, and call them cheap colleges, on account of their action during that time.

* * *

Year by year, ever striving for higher things, have the faculties of these schools improved their buildings and extended their facilities for teaching, and may it be said to their credit, going into their own pocket for funds, and making their personal sacrifices without a murmur. And so far as my personal knowledge of the schools of this State, goes never, but with

a single exception, and that of recent date, through one of the papers of this city, calling on the laity for assistance to complete and equip their school.

* * *

Now in the same journal, the Georgia medical schools are taxed for not requiring a three-years term. Some of the schools in this State; to my certain knowledge, offer to their students free tuition for the third term if they will take it, and I am glad to say that the number of those who are taking advantage of this offer are increasing each year.

During the last session of the Legislature of this State, there was a bill before it to enact a law requiring a three-years course of the students of the colleges of this State before they could apply for graduation.

All the colleges seemed to be in favor of it, and my understanding was that there was a tacit agreement that each one of the faculties of the different schools should aid the passage of this law. But, lo! and behold, just as the bill seemed to have every chance of passing by a large vote, the most prominent member of one of the medical schools of this city—a man of rather short but decidedly rotund figure, smooth-faced and the size of whose cheek-s is only equalled by the circumference of girth—appeared before the committee having charge of this bill, and in a speech of large volume and small substance argued against its passage. The bill did not pass. I suppose the committee agreed to kill the bill to stop the speech; for certainly neither the good looks or fascinating manners of this individual could possibly have had any effect.

* * *

Certainly the medical schools of the South have, in the most *positive* way, expressed their *very high appreciation* of the *ability* of at *least one school* of this *section* to *teach* the *very best* and *progressive medicine*, for I see that the Southern Medical College of this city has filled two of its most important chairs with recent graduates from the ATLANTA MEDICAL COLLEGE of this city, one being elected Professor of Physiology, and the other Professor of Chemistry and Lecturer on Pathology. So at *least one* of our colleges graduates students who will make satisfactory professors for other colleges, even colleges

situated in the same city, where, of course, *one who did not know*, would *suppose competition existed.* Honor to those to whom honor is due.

* * *

We do not consider any statistics based upon successes or rejections before the examining boards (not board, for there is one for each county) of Alabama reliables. Our reasons for this opinion is not only derived from personal knowledge, but also upon the condemnation and censure as expressed by the Alabama State Medical Association in their transactions. We copy their own words from this volume, "It has been our disagreeable duty from time to time to be obliged to recommend the censure of our county boards of medical examiners. As a rule, these delinquent boards have recognized the justice of the censure visited upon them."

We should like to go into the methods of the Alabama examining boards more thoroughly, but for lack of space, defer it until another issue.

In closing this editorial, we simply cite the percentage of rejections as given by the editor of the *Virginia Medical Monthly*, who seems to have some pride in the rating of his own section, and who thinks the "Southern States medical colleges are more exacting as to the grade of requirements for medical graduation than are those of the West or North." In his article, the percentage of rejections is as follows:

Southern college graduates, 17.3 plus per cent.
Western college graduates, 18.2 plus per cent.
Northern college graduates, 35.3 plus per cent.

W. F. W.

I had a funny dream the other night. I was standing at the corner of a magnificent new building in this city, admiring the architecture, when I saw a gentlemen coming up the street with a large bottle in his hand, with the magic letters K. R. G. in large type marked on one side. In a moment, another smiling, complacent-looking gentlemen, whom I had noticed coming out of the building with a glass jar under his arm, the contents of which I could not recognize,

met the former in front of me, and not until they spoke, did I recognize them. As they were so close, I could not help but overhear their conversation, which was as follows:

DR. MEDICINE: "Good evening, Dr. Surgery."

DR. SURGERY: "How are you, Dr. Medicine? What's new in your line?"

DR. MEDICINE: "New! Why you must not read the papers. Don't you know we have reached the millenium in medicine? See that bottle?"

DR. SURGERY: "I see three large letters on it."

DR. MEDICINE: "Ah! my boy, those letters stand for the name of this wonderful medicine by which the millenium has been reached. It has just been endorsed by a whole college. You don't believe it? Well, I will read you a letter from the president.

"'We have used King's Royal Germeteur in the Southern Female University during the past year. Among the many boarders, all expressed themselves as highly pleased, and I must say that not an adverse criticism was given. It was the almost universal remedy for every complaint among the young ladies.'

"How is that? What has Surgery got to say for herself?"

DR. SURGERY: "More than you, my boy. You should read the papers and keep up with the surgical progress. You see the contents of that jar?"

DR. MEDICINE: "Yes, what is it?"

DR. SURGERY: "That is an appendix—a vermiform appendix! Cut it out of a man the other day. The most wonderful and delicate operation of the age; second one ever done in America. Read the account of it in the papers, and then you won't come talking to me about your millenium in medicine. If you did not see *the paper* I will get after the printer, for I told him to send out an extra edition."

DR. MEDICINE (as he poked Dr. Surgery in the ribs): "I see you are up to snuff; nothing like being in with the papers." And as they passed on with a mutual chuckle, I awoke from this horrid nightmare. W. F. W.

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SANDERS & SONS' EUCALYPTOL EXTRACT (EUCALYPTOL). Whenever mention is made of "Oil of Eucalyptus" we beg you to bear in mind that such reference applies to our preparation, styled for distinction, "Eucalypti Extract (Eucalyptol.)" To avoid disappointment we would suggest to specify, when prescribing, our manufacture. Samples gratis through Dr. Sanders, Dillon, Iowa. Meyer Bros. Drug Co., St. Louis, Mo., Sole Agents.

ADVERTISING.—If you wish to advertise anything anywhere at any time write to Geo. P. Rowell & Co., No. 10 Spruce St., New York.

At a meeting of the Spanish Medico-Chirurgical Academy, Azna (*Revista de Med. y Cir. Pract.*, March 7th, 1892,) gave an account of his experience of dermatol in surgical practice. Even when employed in large quantity, he said it does no harm; it stimulates granulations, and is particularly useful in skin affections, such as eczema, which are characterized by much discharge, and if dermatol is applied to wounds which have already begun to granulate, it greatly stimulates the process, and similarly in the case of soft chancre after the ulcers have been cleansed with antiseptic lotions, dermatol hastens repair, and brings about rapid and thorough healing.

In diseases of the skin, Azna thinks that dermatol, with its drying and astringent properties, its absolute harmlessness, and the ease with which it can be used, may advantageously replace starch powder, oxide of zinc, etc.

It is also useful in the affections of the female genitals.

I have used Cascara ever since its introduction, but have found no preparation of the drug to equal your Cascara Aromatic for pleasantness and effectiveness. It acts like a charm. In future I shall prescribe it in preference to all other preparations of the drug. W. G. MCDOWELL, M. D.

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Dose—A teaspoonful in water, gradually increased to a tablespoonful, three or four times daily.

ALTHOUGH our Verrhus Clemiana has been before the medical profession for only about two months– too short a time to be fully tested in the chronic diseases for the cure of which it is recommended—we have received quite a number of letters setting forth the flattering results already obtained. We submit the following extract as a sample :

"ST. SIMONS MILLS, GLYNN CO., GA., April 11th, 1892.

"Clemiana Chemical Co., Atlanta Ga.:

"Gentlemen:—In reply to your inquiry of 9th inst., I can safely say that you have the most powerful alterative I have ever prescribed, and it gives me pleasure to make the statement.

"Yours very truly,

"ALEX. B. MCCASKILL, M. D."

"COLUMBUS, GA., May 9th, 1895.

"Clemiana Chemical Co., Atlanta Ga.:

"Gents:—I am so much pleased with your Verrhus Clemiana I have had my druggist order the second lot.

"If it continues in favor as it has started, I shall say it is a most valuable medicine and will receive the deserved attention of our professien. I am delighted with it thus far.

"Yours, etc.

"THOS. S. MITCHELL, M. D."

We will be exceedingly obliged to all physicians who will report their experience in the use of this medicine.

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I reiterate my assertions made nearly a year ago, and am daily prescribing Antikamnia with happiest effects.

In my practice, it accompanies the maid from her virgin couch to her lying in chamber, assuaging the perplexities of maidenhood and easing the trials of maternity with most gratifying results.

I earnestly hope that the proprietors of this valuable remedial agent will keep it up to its present standard of purity and excellence. Truly,

CALEB LYON, M. D.

Doctor, are you acquainted, by practical experience, with the success of the hypophosphites of lime and soda (Churchhill's treatment) in consumption? Read the excellent article, "New and Old Cures for Consumption," on last page of this issue.

Dr. M. Chaper, Grenoble, France, says: "I have never known a soporific so efficacious as Bromidia, except morphine, and morphine is not so agreeable, and has inconveniences which I have not discovered in Bromidia. I have used this latter preparation frequently, and it has never failed in producing the desired effect.

Pocket map of Georgia and Florida—handsomer, handier, *better*, than any fifty cent map yet made; seven colors; in strong cover; all counties, rivers, railroads, post-offices. Correct to date. Also maps of States in same style. Agents wanted. Even boys and girls make money fast. We mail agents any samples wanted on receipt of fifteen cents each; Address Matthews-Northrup Co., Buffalo, N. Y.

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CHLORAL IN THE TREATMENT OF BOILS.—*Bull. Gen. de Therapeutique.* By *M. Sphen.*

The author recommends very highly as far superior to all other treatment, the use of chloral externally, in this troublesome class of affections. He directs that the boil be kept covered with a tampon of cotton-wool, soaked in the following solution:

R. Chloral hydrat, oz. iiss.
Aquæ,
Glycerin, aa. f. dr. v.

M.—*American Medical Magazine.*

EMMENAGOGUE.—

An excellent emmenagogue is given in the *Medical News*, Cincinnati, as follows:

R. Hydrargyra bichloride,
Iodii arsenitis, aa gr. iii.
Strychiniæ sulphatus, gr. ss. (½)
Potassii carbonatis,
Ferri sulphatis, aa gr. xlv.

M. In pilulas lx. divide. S. One pill after each meal.

TAPE WORM.—

Dr. T. W. Shaw, of Pittsburg, advises:

R. Kamala, 1 dr.
Ethereal ext. male fern, 2 dr.
Syr. acaciæ, 1 oz.

M. S. To be given in two doses, one-half on rising in the morning, and the other half two hours afterwards. A dose of castor oil to be given one-half hour after the last dose.—*Ex.*

CHOREA.—

The following was given with great benefit in *DaCosta's Clinic* to a girl suffering from chorea.

R. Tr. belladonnæ, dr. ʒ.
Liquoris potassii arsenitis, dr. ij.
Syr. hypophosphitis comp. q.s., oz. iij.

S. Teaspoonful ter in die.—From *Medical News.*

FISSURED NIPPLES.—

R. Balsam Peru, ½ dr.
Tinct. arnica, ½ dr.
Oil sweet almonds, 1 oz.
Lime water, ½ oz.

M. S. Apply a small quantity several times daily.

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Original Articles.

INTERSTITIAL NEPHRITIS.*

BY W. O. BRIDGES, M. D., OMAHA, NEB,
Professor of Clinical Medicine, Omaha Medical College.

In selecting the above subject for a paper, I have done so with a view to call your attention to a disease which, experience has led me to believe, passes through its earlier stages unrecognized to a greater extent than any disease with which I am familiar, and also to insist upon the simplicity of its relatively early diagnosis, and the means at our command for its timely management.

By interstitial nephritis is meant an inflammation of the connective tissue of the kidney, always chronic in character, and in accordance with the unvarying law of connective tissue proliferation, leading to contraction of the organ, and consequent atrophy of the excreting apparatus; hence, occasioning what is known as the cirrhotic or contracted kidney. I wish here to emphasize the discrimination between interstitial inflammation of the kidney, occurring *de novo*, and as a sequel of chronic parenchymatous nephritis. It is with the former

*Read before the Nebraska State Medical Society, at Omaha, May, 11, 1892.

that we have to deal. I stated that in a large proportion of cases, this disease passes unrecognized until the manifestations of its latter stages appear, and the probable reason is found in the want of uniformity of its early symptomatology, and the absence of such indications pointing to kidney disease, as usually lead us to examine the urine. To illustrate, I will briefly cite a few cases which have come under my observation in the past few years:

CASE I. H. N., aged 28, was a clerk by occupation; he had had scarlet fever in childhood, recovering without known complication or sequel. He had not been in robust health, and was occasionally troubled with an eczematous eruption of the hands. He had consulted physicians several times during the preceding year or two, for debility, depression of spirits without known cause, and had taken tonics with temporary benefit. The preceding winter he had complained of shortness of breath on exertion, but this was attributed to general debility. Suddenly one night, he was seized with an asthmatic paroxysm followed by cough and bloody expectoration. This was repeated on the two following nights, each being relieved by dry cupping over the chest. Before the third attack he felt able to attend to his duties in the day time, but following this one, he had a temperature of 101 degs., and fine moist rales were manifest over the entire chest. The countenance was pale, lips colorless, no œdema. An examination of the urine for the first time, showed a specific gravity of 1007, and a trace of albumen. On close questioning, he stated that during the past one and one-half years, he had been in the habit of rising earlier than usual to urinate, and latterly, the amount had increased considerably. There was no œdema, no dyspeptic symptoms, no headache. The heart was markedly enlarged, the apex beat being an inch below and to the left of the normal. There were no murmurs, but the second sound was much accentuated. A diagnosis of interstitial nephritis was made. From this time until his death, six months later, the chief symptoms were referable to the respiratory system; paroxysms of asthma mostly at night, followed by two or three days of pulmonary congestion and œdema, severe dyspnœa, attacks of œdema of the glottis of very short duration, and

always terminating in intense swelling of the soft tissues about the larynx. At these times, suffocation appeared imminent, and was relieved only after hypodermics of pilocarpine.

Frequent examinations of the urine, showed albumen in varying quantities; always slight, specific gravity never reaching above 1009; amount from two to three quarts daily, very pale in color. Occasionally there was slight œdema of the feet and eyelids, and towards the last he had nausea and some vomiting. He died in uræmic coma.

CASE II. Was a grain dealer, 40 years of age, who had contracted a venereal sore in his early manhood, which was pronounced specific, and which disappeared under mercurial treatment kept up for only a few months. There were no secondary developments. He had a resilient stricture of the deep urethra, which necessitated the use of the sound once a month; this had been resorted to for many years. For a year previously he had been troubled with periodic headaches, which were followed by slight dyspeptic symptoms, and he had lost thirty pounds in weight. Latterly, the headaches had become more frequent and severe, and he had consulted several medical men, who pronounced his attacks bilious in character, and treated him accordingly, with temporary improvement. His headaches were peculiar, occurring always at four o'clock in the morning, and becoming so severe that he was obliged to rise and pace the floor until his servant could prepare very strong coffee, which afforded sufficient relief to enable him to rest again. By noon of the same day, it disappeared and left him weak and with slight nausea. The attacks recurred weekly on the same day at the time he consulted me, and I was inclined to the diagnosis of malarial infection. He was therefore given calomel and large doses of quinine preceding the expected attacks, which served only to postpone them, the effect probably being from calomel. A more thorough examination now revealed slight œdema at the ankle, and the urine was pale in color, specific gravity 1009, no albumen. A subsequent examination showed a trace of albumen; quantity in twenty-four hours, three quarts. All treatment gave only slight relief to the headaches; some of the seizures were so severe as to necessitate chloroform anæsthesia.

He was growing worse as the fall advanced, and on my advice, he went to Southern California. Here he remained until the following May, having only one attack soon after his arrival in San Diego. He improved in every way, except he did not regain his flesh. He returned here to his work apparently well. Urine still increased in quantity, specific gravity varied from 1011 to 1013, only occasional traces of albumen; no œdema, no dyspepsia. Improvement continued dur- the summer; as the fall advanced his headaches returned, and in spite of the warning given by their increasing severity and frequency and my advice, he delayed returning to the sunny clime until December. On the way, his train was delayed by severe storms in the mountains, he took cold and developed uræmic convulsions, which continued irregularly until he died, several weeks later in coma.

CASE III. L. K., a female servant, aged 27; had not been well for two years, during which time she had been treated by several physicians for heart disease and bladder trouble. Symptoms of bladder irritability had been manifest in frequent desire to urinate for many months, and latterly the urine was always cloudy. She had very slight puffiness of the lower eyelids, and there was occasional œdema of the feet. Nausea and vomiting occurred frequently, and at times the stomach would not tolerate any kind of food for several days. The heart was much enlarged, and a mitral systolic murmur detected. The urine was increased to over two quarts in twenty-four hours, and contained so much sediment consisting of pus and stringy mucus, that it was necessary to filter each specimen before the urinalysis could be completed. The color was pale, specific gravity 1005, albumen in very small quantity, large hyaline casts were found under the microscope. A diagnosis of cystitis, interstitial nephritis, and mitral insufficiency, was made. She has been under my observation for nearly two years.

Rapid improvement followed treatment of the cystitis, and she resumed housework. Several examinations of the urine have shown a specific gravity varying from 1002 (which was found more than once) to 1007, and always a trace of albumen.

In the absence of any rheumatic history, I considered the heart trouble secondary to an interstitial nephritis.

CASE IV. M. A., aged 27, had been a sufferer from dyspeptic trouble for two years. She had lost flesh and was in very depressed spirits. Diphtheria in childhood without known sequel was the only illness reported previously. All treatment had been directed to her stomach difficulty, and she was discouraged at its failure to relieve. There was no œdema, the heart was enlarged without valvular lesions. She excreted three quarts of urine in twenty-four hours. It was pale, specific gravity 1009, and contained albumen in small quantity. Several subsequent examinations gave about the same result. A consultation with an eastern physician of note corroborated a diagnosis of interstitial nephritis, and she was advised to remain in southern California one year. There she improved rapidly, her dyspeptic trouble disappeared, and in nine months she had gained twenty pounds, when she returned home. The urine was still increased in quantity, was pale, specific gravity 1015, no albumen. In the past year and a half she has lost and gained alternately; lost during her stay at home and gained when in a warm climate. Her principal complaint is of dyspepsia and depesssion of spirits. Occasional traces of albumen are found in the urine, and the specific gravity is persistently subnormal.

The above all represent cases which had gone on with varied symptoms, from one to two years without a diagnosis of nephritis having been made.

Symptomatology.—Probably the earliest symptom of interstitial nephritis is an increase of the quantity of urine excreted; but this is so gradual, and is so insidious, that the patient's attention is hardly attracted to it until long after other symptoms have developed; in fact, very often it will not have made an impression upon him until the physician makes special inquiry concerning it. This will have been manifest by a desire to empty the bladder earlier than the accustomed time for rising, and as time goes on the patient is obliged to get up earlier and sometimes several times during the night. Gradual loss of flesh, decreasing strength, anorexia, depressed spirits, paleness of the skin and particularly

of the mucous membranes are common to all cases. Localized œdema is probably present at some time in every case, but it is not an early symptom and is most frequently found affecting the lower eyelids or the connective tissue above the ankles. It is so slight at times as to be scarcely perceptible, and careful examination for pitting on deep pressure only reveals it. Occasionally œdema occurs in unusual locations, as is shown in one of the above cases, where it appeared in the soft tissues over and about the larynx. There is hardly any region where it does not occur, but it is to be remembered that it differs from œdema occurring in other varieties of nephritis in being transient and regional. Like that in all varieties, it is my experience that it is worse in the morning than at night, a fact which is not commonly mentioned.

The heart is usually enlarged, and the degree of the hypertrophy corresponds to the duration of the disease, and probably to the diffuseness of the inflammation. In this connection the pulse is hard, incompressible, and the radial artery can be felt nearly to the elbow, a condition which represents a change in the arterial wall, which is supposed by its increased resistance to be accountable for the cardiac hypertrophy. Other symptoms have reference to the digestive, respiratory and nervous systems, and are by no means uniform. As a rule, the indications point so stronly to one of these, that in the absence of other well-marked evidences of kidney disease, an error in diagnosis is commonly made, and the patient supposed to have some affection of the stomach, the lungs or the brain.

Probably in most cases the digestive organs appear at fault. Distress after eating, nausea, vomiting, torpor of the liver, at times constipation, and again diarrhœa, are the most frequent. In another class, headache, extreme nervousness, sleeplessness, mental depression, and later convulsions, followed usually by coma, are found; and in still another, attacks of pulmonary œdema and congestion. Bronchitis, asthma or affections of the glottis make up a marked part of the clinical history. There is a peculiarity about any or all of these classes of symptoms, however, which I have learned from observation, and that is their explosive and intermittent char-

acter. This was markedly illustrated in two of the cases above reported; so much so in one that I was inclined to regard the case as one of malaria, until my error was suggested by a failure in the treatment advised. These outbursts are undoubtedly due to an overdose of urea, and hence occur only after the disease has made considerable progress. Eye symptoms, not uncommon in other varieties of nephritis, are frequent in this, but toward the last, when uræmic poisoning is more marked, there is sluggishness of the pupillary reflex, which gives to the eye a vacant expression, and occasionally temporary amaurosis occurs.

The urine always presents indications which are characteristic of this affection, and if intelligent urinalyses were more frequent in the daily investigation of cases, fewer patients would go on to advanced cirrhosis of the kidney unrecognized. The color is pale, amount increased, specific gravity subnormal, and these conditions are constant. Albuminuria may or may not be constant. It is generally slight in amount, and frequently repeated examinations at intervals are essential before it is found. The presence of casts is also variable, and when detected, they are of the hyaline character.

The etiology of interstitial nephritis is somewhat obscure. Opinions differ as to the relation of the ordinary causes given in the books—syphilis, spirit drinking, lead poisoning and hereditary influences—to this disease. Frequently other conditions existing in an individual may be assumed to act as an exciting cause. In two of the cases before referred to, I believed a chronic inflammation of the urethra in one and of the bladder in another to be the cause. In the other two, there was no ascertainable cause, unless it existed in a preceding diphtheria in one and scarlet fever in the other. Could not these diseases in childhood be the cause of an interstitial inflammation of the kidney, which progressed so slowly as not to be recognized until adult life, or could not a parenchymatous inflammation, the result of such a disease, be recovered from and yet start the interstitial inflammatory process? In view of the well-known fact that diphtheria and scarlet fever have a strong affinity for the kidneys, and that interstitial nephritis is not so infrequent before thirty years of age, I

think it reasonable to answer these questions in the affirmative.

The diagnosis is not difficult. The reason for its delay is found in the apparent indifference on the part of the physician to investigate the condition of the urine, and the absence of well defined symptoms pointing to the kidneys as the seat of disease. The patient is always ready to state that his urine is all right, that it is as clear and free as possible, and his medical adviser is too apt to accept this explanation as denoting absence of kidney troubles. In practice, I have come to make urinalyses as frequently as I look over the lungs and heart in examining patients, and in all cases presenting clinical histories not corresponding to recognizable disease or conditions, or in apparently simple troubles not yielding to treatment, my first thought is of the urine. An error which I believe to be widely prevalent, too, is the dependence which is placed upon the presence or absence of albumen in determining an opinion of the condition of the kidneys. A urinalysis for practical purposes is not complete without noting quantity of urine in twenty-four hours, color, re-action, specific gravity, presence or absence of albumen, and without such, one is not justified in reaching a conclusion as to renal disease. The urine must be depended upon in the diagnosis. If then, in a given case presenting any phase of the clinical history already cited, the urine be found constantly increased in amount, of pale color, low specific gravity, to contain albumen in small quantities, occasional or constant, we are justified in making a diagnosis of interstitial nephritis. I would not hesitate to pronounce upon a case which presented only the above urinary conditions, with hypertrophy of the heart, without another symptom; in fact, a low specific gravity and a trace of albumen alone are strongly suggestive, and if constant, a diagnosis would be corroborated by the subsequent history.

This disease should be discriminated from other varieties of nephritis, as the differentation has a marked bearing on the prognosis. Chronic parenchymatous nephritis is attended with constant œdema, oftimes anasarca, the heart is not so constantly enlarged, the urine is not so increased in quantity,

has more color, always contains albumen in considerable amount, and the specific gravity is subnormal and may be increased in the early period. The disease comes on more rapidly and runs its course in a shorter time. If prolonged for a number of years, interstitial inflammation is a consequence, and we have a mixed disease which presents more the history of the latter, but the entire clinical history will enable us to determine its commencement in the former. Acute parenchymatous nephritis would hardly be confounded. The urine here is of high specific gravity, contains even a larger amount of albumen and is less than normal in quantity.

Pathology.—Many years ago, Gull and Sutton called attention to a general arterial sclerosis which was found in all cases of interstitial nephritis, and after studying carefully many hundreds of autopsies in which these conditions were associated, in some of which there had been no evidence during life of any kidney affection, the patient dying of an intercurrent disease, they maintained that the nephritis was but a local manifestation of a general pathological process having its origin in an inflammation of the intima of the blood vessels; in other words, that the cirrhotic kidney was a constitutional rather than a local disease. They explained, on this theory, the dependence of the cardiac hypertrophy upon the interference with the general circulation occasioned by rigid arteries. Pathologists are still divided as to the correctness of this theory, the opposition maintaining that the arterial sclerosis is the result of chronic uræmia and occurs in other varieties of chronic nephritis, and also, that if the constitutional theory was correct, the inter-cellular tissue of other organs than the kidneys would be equally involved. Certain it is any way that the disease is manifest in an inflammation of the connective tissue structure of the kidney, which leads to contraction and consequent atrophy of the excreting portions. This process may or may not be equally diffused through the organs, hence the variation in the duration of the disease.

Prognosis.—As to absolute recovery, the prognosis is most unfavorable, yet the disease may last for many years, and the patient be in apparent good health. Conditions of climate,

occupation, habits, so affect the disease for better or for worse that the subjects, so to speak, hold their lives in their own hands. Acute inflammatory diseases, as intercurrent affections, render the prognosis as to time unfavorable, and particularly is this so of acute nephritis which is most liable to precipitate a fatal acute uræmia.

Treatment.—Nothing is to be expected in the way of cure, hence all efforts should be directed to retarding the progress of the affection. A kidney, which is the seat of interstitial inflammation, is a permanently damaged kidney, and it should be relieved of its work to the greatest possible degree. The chief indications to this end have reference to limiting the production of urea and its compounds in the economy, and attention to the healthy action of those organs which act supplementary to the kidneys, namely, the skin and bowels. The first indication is accomplished by a restriction of the ingestion of urea-producing foods to the lowest point consistent with good nutrition, and the avoidance of all articles which are not easy of digestion and transformation into tissue-building elements. With these objects in view, it is that milk alone has for many years been selected as the ideal food in kidney diseases. That it has any specific or curative effect, I do not believe. When it can be well borne and taken in sufficient quantities, it certainly answers an excellent purpose, but milk is a much abused food; few patients will admit that they can take it in such quantity as is considered necessary to sustain life. One of mine was quite rebellious until he learned not to drink it, but to sip it, and consumed three-quarters of an hour taking a quart. This he kept up three times daily for nearly a year before he increased his diet, and then he was not anxious to do so.

The second indication is to keep the skin active—constantly active—not by depleting measures, but by the natural method, a warm atmosphere, and this should be as uniform as can be found. I believe the climatic treatment of all forms of chronic nephritis is of greater importance than that of phthisis. Two objects are attained by a warm climate which presents the slightest variations the year round, the production of a constant perspiration and the freedom from the possible

danger of sudden chilling of the surface, and I believe it is a mistake for patients who are able to permanently take up an abode in such a place not to do so. Temporary residence only involves climatic changes which are too often productive of harm. The chief indications having been fulfilled, other treatment has reference to management of symptoms which will vary in different cases.

SEXUAL HYPOCHONDRIASIS.

BY C. EVANS JOHNSON, M. D., ATLANTA, GA.

Every one who does any work in the line of venereal diseases has had to deal to a greater or less extent with that peculiar class of cases termed sexual hypochondriacs, who apply complaining of an abnormal condition of things relative either to the appearance or the functions of their genital organs.

These patients are of two distinct classes. There are those who need only to be assured by you that both the appearance and the functions of these organs vary in different individuals and are yet normal, and those who refuse to accept all such statements—whose minds are really unsound in regard to this point, and who, unless something is done for them, and some pretense at treatment is made, will continue brooding over their supposed troubles, leading a life which is a burden alike to themselves and those around them, until their fitful career is ended within the walls of an asylum for the insane, or they fill a suicide's grave.

You will be consulted by men declaring that they have noticed a few herpetic vesicles appearing from time to time upon the penis and scrotum, that one testicle hangs lower than the other, that they have nocturnal emissions once or twice a month, that during an effort at sexual intercourse, ejaculation occurs before an entrance can be effected, or, possibly, they are suffering from impotence which will be found to be purely psychical.

But nocturnal emissions are the source of complaint of the greater number of sexual hypochondriacs, and will be

ascribed by them to masturbation, which will be found to have been only moderately practiced by them in former years. Even men who have enjoyed a period of many years of vigorous sexual powers, and who, by reason of being left widowers or because of the ill-health of their wives are leading a life of continence, will ascribe an occasional nocturnal emission to their early indiscretions.

If such patients as these enumerated happen to be blessed with common sense, the majority can be convinced that the herpetic vesicles are of no consequence; that it is perfectly natural that one testicle should be the lower (which, in the greater number of instances, will be found to be the left, because of the fact that most men dress upon the right side, displacing the testicles to the left); that nocturnal emissions occur independent of the practice of masturbation, it frequently being found in subjects who have never masturbated, and is incident to early healthful manhood; that their premature ejaculation is due to excessive stimulation of the passions and their anxiety to complete the sexual act, occurring most frequently in newly married men and those practicing illicit sexual intercourse; and that their impotence is not a pathological condition, is due wholly to the influence of the mind and can be corrected by themselves through exercise of the will-power.

The patients require little treatment, but must be dealt with plainly, and if they can be made to see that you are honest with them, and you can get their confidence, the battle is won. But some are not so easily convinced, and it is often necessary to administer a "placebo" purporting to have a powerful effect, which will generally accomplish the end desired.

However, every patient who comes to you complaining of night emissions, premature ejaculation and impotence cannot be styled as belonging to this class of patients. This should be carefully looked into. If he has ever masturbated, it must be ascertained to what extent it has been carried, the patient must be closely questioned as to gonorrhœa and syphilis, and all statements duly weighed and accepted with proper reserve, and the mind of the physician fully satisfied as to the com-

plaints of the patient being wholly without foundation—a thorough examination being generally deemed advisable.

Nocturnal seminal emissions are usually met with in young men between the ages of sixteen and twenty-five. At this period the sexual functions are most active, and the secretion of semen is continually going on, and must give itself vent in either one way or another. It is, of course, governed to a greater or less degree by the habits of the individual, and will depend somewhat upon the purity of his thoughts, and whether the sexual desires have ever been excited by masturbation, illicit sexual congress or the marriage relation. But to find a healthy young man of ordinary intelligence, living continently, and surrounded by the ordinary environments, and pursuing the usual walks of life, who does not have an occasional nocturnal emission, is an exceedingly rare instance. Usually these emissions are found to occur once a month or once a fortnight, but they may occur two or three times a week without any detrimental results to follow; again, the patient may, for several weeks, be entirely free from them, when they will appear upon several successive nights or even upon the same night.

Bumstead says: In ninety-nine cases out of one hundred, these emissions require no medical or surgical treatment. The chief danger from them lies in the patient attaching undue importance to them, in dwelling upon them, and in making himself miserable over them. If he can be induced to give his mind and body pure thoughts and healthy exercise, and to look upon their occurrence as a physical necessity, nature will take care of the rest.

As to masturbation being the most frequent cause of nocturnal emissions, I wish here to quote the words of Sir James Paget[1]: You may teach positively that masturbation does neither more nor less harm than sexual intercourse practiced with the same frequency, in the same conditions of general health and circumstances. Practiced frequently by the very young—that is, at any time before or at the beginning of puberty—masturbation is very likely to produce exhaustion, effeminacy, over-sensitiveness and nervousness; just as

1 Clinical Lectures and Essays, London, 1875.

equally frequent copulation at the same age would probably produce them, or practiced every day or many times in one day, at any age, either masturbation or copulation is likely to produce similar mischiefs or greater. And the mischiefs are especially likely or nearly sure to happen, and to be greatest, if the excesses are practiced by those who, by inheritance or circumstances, are liable to any nervous disease—spinal irritation, epilepsy, insanity or any other. But the mischiefs are due to the quantity, not to the method of the excesses; and the quantity is to be estimated in relation to age and the power of the nervous system. I have seen as numerous and as great evils consequent on excessive sexual intercourse, as on excessive masturbation; but I have not seen or heard anything to make me believe that occasional masturbation has any other effect on one who practices it than has sexual intercourse, nor anything justifying the dread with which sexual hypochondriacs regard the having occasionally practiced it. I wish I could say something worse of so nasty a practice; an uncleanliness, a filthiness forbidden by God, an unmanliness despised by men.

Marriage has been advised, whenever practicable, for young men of this class, and while it usually accomplishes all that is intended it should, physicians should be very chary in urging this point, and is admissible only when it is absolutely certain that there exists those conditions and circumstances which combine to make a happy marriage, and is not simply a union having for its purpose sexual intercourse, for marriage under these conditions is likely to entail far greater evils than can ever result from nocturnal emissions; nor is illicit sexual congress ever to be advised in lieu of marriage, because of the fact that it invariably leads to excesses which have an effect entirely at variance with the end desired, and leaves the patient in a far worse condition than he was originally.

Another very frequent complaint of this class of patients is a too speedy ejaculation in the effort at coition, which may take place in attempting intercourse with any woman, or with some one woman in particular, especially if the attempt be the first one with her. Here the mind is at fault; over-anxiety to perform the act well is very apt to its being done

badly. Young husbands in their eagerness to consummate the rite, not infrequently fail, and I fancy that there are few men who did not ejaculate prematurely when they had connection for the first time.

In January, 1892, I was consulted by a young man, H. E. L., age 22, book-keeper, for premature ejaculation of semen. Came to me in great distress. Had been married four days, and upon first attempt at sexual intercourse, had failed utterly because of ejaculation of semen before intromission could be accomplished. Had not since made effort at repetition of act, fearing he would again fail, and dreading further mortification. Found he had never masturbated, had never had gonorrhœa, nor had he ever been so troubled before in attempting intercourse with other women. I explained to him that his failure was most probably due to normal impetuosity and want of self-control, telling him that it was frequently the case in newly-married men and that he would not likely have any further trouble upon a second effort. On the way to my office next morning, I chanced to meet him, when he greeted me with a happy, confident smile and passed on.

Impotence from the restraining or inhibitory control of the brain over the genito-spinal centre is a condition often met with. That erection may fail or cease under the influence of excitement, depressing or other emotions, or mental preoccupation, is a fact with which every one is familiar.

Thus, it will be found in the history of nearly all cases of rape, that where a considerable struggle has taken place, the performance of the act has been more or less imperfect, due to the muscular exertion, the excited state of the mind and the difficulty attendant upon its performance. Young husbands who were previously potent, and had never indulged in sexual or unnatural excesses, or young men about to have illicit sexual intercourse with some young woman for the first time, are liable to be troubled in this way, the undue stimulation of the passions at their first efforts at copulation having the effect of causing the erection to cease before the act is completed, or even before intromission. As in premature ejaculation, repetition of the effort generally corrects the trouble.

The satisfactory accomplishment of the sexual act can be influenced by the most absurd fancy or the merest whim. One man will be told by a friend of his sexual weakness, and with this story in his mind, he too, will find himself unable for a time to complete the act. The utterance of a vulgar expression, or a coarse word by a woman, may take away all desire for her, and the power and desire yet remain for others. Excessive desire, with gratification long delayed, may temporarily deprive a man of his power.

One of the most frequent causes of impotence, is the fear that coitus is impossible, and you will be told by patients that the moment intercourse is attempted, no matter who the woman may be, or how passionately fond he may be of her, the power leaves him entirely, although the desire is excessive.

Grimaud de Caux[2] relates the instance of a mathematician in whom erection ceased before ejaculation, because his thoughts wandered to the solution of an intricate problem. The wife resorted to the stratagem of partially intoxicating her husband before the attempt at connection, which rendered his powers all that could be desired.

Ribaud[3] relates the story of a young Frenchman who was given the initiatory steps into the pleasures of Venus by a young woman occupying the position of governess in some one of the neighboring country homes, who was a blonde, and always wore when she met him, English boots, corsage and blue silk dress. After a time it became desirable by his family, that a marriage should be consummated by him, but he found himself impotent except under the conditions that the woman be a blonde, she must wear English boots, corsage and blue silk dress, under which circumstances, his powers were vigorous enough. Ribaud, under pretense of giving him a powerful drug which would certainly cure him, administered a "placebo" which brought about the desired result.

Onimus and Legros[4] speak of a young man who was impo-

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2 Physiologie de l'Espece.

3 Traite de l'Impuissance et de la Sterilite.

4 Traite d'Electricite Medicale.

tent for years after having been surprised at the moment of connection by the husband.

I mention these instances to illustrate to what extent a man's powers may be governed by his mental condition, and the importance of obtaining the confidence of patients who apply afflicted with these imaginary troubles.

INCOMPATIBLES OF ANTIPYRIN.—The *Pharmaceutische Centrallbatt*, No. 29, 1892, gives the following incompatibles of antipyrin which precipitate the antipyrin from a concentrated solution: 1, concentrated solution of carbolic acid; 2, tannic acid, and preparations containing it; 3, tincture of iodine; 4, the chlorides of mercury. The following substances, also, decompose antipyrin when triturated with it: 1, calomel forms with antipyrin a toxic combination; 2, antipyrin is decomposed when rubbed with beta-naphthol; 3, with chloral, antipyrin forms an oleaginous liquid; 4, with bicarbonate of sodium it disengages the odor of ether; 5, salicylate of sodium, equal parts with antipyrin, forms an oleaginous mixture.—*Medical Age.*

LACTIC ACID AS A PROPHYLACTIC IN GOUT.—Berenger-Feraud (*Journal de Medicine de Paris*, 1892, No 15, p. 181) recommends the employment of lactic acid to prevent the gouty attack. To six hundred grains of the acid is added sufficient water to make a solution of twenty teaspoonfuls, each teaspoonful will thus contain thirty grains. Every morning a teaspoonful of the solution is added to two or three glasses of sweetened water and drank in the course of the day. At the end of twenty days the medication is suspended for ten or twelve days, and then resumed. The treatment should be continued for several years. The remedy is inoffensive, and does not interfere with the digestion or the nutrition.—*Medical Age.*

Plate III.

THE RADICAL CURE OF HERNIA, PARTICULARLY WITH CHILDREN.

BY DR. G. FELIZET, SURGEON TO TENON HOSPITAL, PARIS, FRANCE.

Translated by THOS. H. MANLEY, A. M., M. D., Visiting Surgeon to Harlem Hospital, New York.

(*Continued.*)

OPERATION FOR THE RADICAL CURE OF HERNIA.

Here many eventualities are to be considered.

(*A.*) *The hernia is entirely reducible.*

(*B.*) *The hernia is only partially reducible.*

(*C.*) *The hernia is absolutely reducible by adhesions.*

(*D.*) *Finally, after division of adhesions in a kelotomy for strangulated hernia, we may practice the operation at the same time for radical cure.*

(*a.*) The hernia is reducible in its totality.

This is the most simple variety and is the variety most common in children. It will serve us as a type. The easy return of the hernia is effected in the majority of cases.

But sometimes there are many loops of the intestine down, and their reduction, which *a priori* would seem a very simple matter, is very difficult and laborious, as we will sometimes find a fresh loop descend as the others are pressed backwards.

It was in a case of this description that I performed my second operation on a child 8 months old. The hernia was double, which unavoidably prolonged the operation beyond the limits to which we are accustomed.

The hernia being reduced, the finger is engaged in the opening of the sac which protects the two edges of the wound, and we explore things. This exploration must be rapid, but not too methodical. The finger is now carried to the base of the sac and the testis felt. If we touch the tunica albuginea, we are certain that we have what is anatomically known as a real congenital hernia. If, in an infant, we do not find the testis in the base of the scrotum, we must search for it. The

finger is carried towards the ring. If the testicle is at the external orifice, it should be drawn downwards a little and engaged in the track, to assuré not only the return of the intestine, but besides, to assure one that there are no adhesions involving the internal orifice. If the testis is at the internal orifice, the finger will test mobility and facilitate its descent. At last, if the testicle cannot be found; if it is perhaps recognized as an abdominal ectopy; that is to say, in such a condition in which it has escaped internal strangulation at the ring, it should be directed towards its normal passage.

I have always insisted that we should not hesitate because of these two latter eventualities. I have not yet met and operated for radical cure on these latter, as they are not numerous; so that in default of my own experience, I must have resort to that of other surgeons. If we should encounter this condition in an acquired or congenital hernia in an adult, with the testis having migrated into the abdomen, the important result of this exploration and operation would be to furnish him assurance against compression or incarceration of the organ of generation.

3rd Stage—With the finger which has explored the sac, the neck and abdomen, we quickly substitute the folded balloon; engaging its small extremity in the inguinal tract as deeply as possible. The balloon is now fixed in the sac; two sutures or forceps retract the opening above and below the tube, and in a minute it is insufflated. We see, while it is filling with air, the small extremity of the pear-shaped extremity of the air-bag engage in the inguinal tract, so that its apex is opposed to the retreating intestine during the operation. From this moment, the situation is simplified, and the procedure expedited.

We now have before us a hernia which we may deal with at our leisure; which we may attack with circumspection, free from all dangers; we have in reality, the ideal of a tumor, hard, glistening, regular, well circumscribed and mobile, which we may seize and enucleate with its peritoneal pedicle attached, which surrounds and distends it. Although the sac may have been primitively *cylindrical, conoid, globular*, or

moniliform, it is of no consequence, as it is now maintained of a regular pisiform shape. The shape of the sac has now no interest for us; what now interests us, is the neck of the sac, its exact dissection and its strict isolation up to the internal orifice. The entire rent in the sac being closed with the forceps, we make a circular section which presses the cellular envelopes until we see clearly the red tint of the gauze through the thin sac. We now introduce a grooved dissector, and with the bistoury or scissors we divide the coverings along the line of the cutaneous incision, as high as the external orifice of the inguinal canal. Guided by its pellucid hue, we are soon on the sac. The incision is continued downward in the same manner. From this, through the remainder, is but a matter of a few moments; with the scissors, finger and canular in, split the tunics, rendered clear by the uniform tint of our balloon. We are certain not to have left the contour of the protrusion, nor to have mutilated the soft parts, the preservation of which is necessary.

We are certain that we have preserved the elements of the cord; the spermatic canal, which is so small, so slightly visible in an infant; the spermatic veins, which we see in their sheaths, as the balloon rises, of a red and blue shade, without the loss of a single drop of blood. The spermatic artery is in great danger of being wounded, as it floats in its flexuosities in its bed of soft tissues, badly situated, obscure and but feebly supported. The nerves, one does not see, as they are blended with the other elements.

In some, the fingers meet posteriorly to the sac, and we may completely liberate the serous pellicle, after the manner in which we would enucleate a sarcocele. The greatest delay is in completely isolating the neck as high as possible. If, however, the incision into the integument is high enough and the rent in the distending bag is well maintained in the tract, the enterprise is easy. We must now make a certain traction on the peritoneum as low as possible, using the bistoury and tenaculum to freely separate it.

If the red tint of the rubber is everywhere fine and regular, we are sure the bottom only distends the sac, and that the intestine is not pressed or included. In order to be more

positive yet, we execute a simple manœuvre. We give the sac two or three turns, while with the fine raspatory we scrape the pedicle till it is reduced to extreme thinness.

We may now proceed with every security, and transfix with a double suture the summit of the sac, using either catgut or silk, applying the knot tightly in the ordinary way. The section of the pedicle is made one centimetre below the divided pedicle. The end of the ligated sac quickly rises and is lost in the belly. We now protect the parts above with an antiseptic sponge. If the sac has been detached wholly below, we may now utilize what is left of it to facilitate its dissection.

We are now assured of a rapidity in operating without thoroughly freeing and seeing the sac and isolating its pedicle. Its density is a consideration, for with one hernia in an adult, measuring three or four times the size of the thumb, it weighed 3 grammes, and in one of children, recently operated on, 28 centigrammes. If a hernia appertains to the congenital variety, and if the testis is at the base of the sac, we must always preserve the peritoneum which constitutes its serous envelope In this case it is easy, but it is not always necessary to suture. The serous surfaces are approximated, their borders trimmed sufficiently to assure space for the spermatic cord and tunica vaginalis.

With reference to sewing the pillars of the rings together, there is a question which demands further study, and hence, positive opinions must be reserved. What we wish to say is, that the operation of suturing them is very simple and harmless always, when we carry the incision of the integument far enough, dissecting in a systematic and methodical manner the sac from the diverging columns. Nothing will accrue from an operation which leaves the neck of the sac neither perfectly isolated, independent, nor continuous.

(*b.*) The hernia is reducible in part only.

We have so far considered only the least complicated. A simple sac, peritoneal or peritoneo-vaginal, free from all adhesions with the intestine or epiploon. These are the varieties most commonly met with in children. The epiploon which attaches itself with most facility to the parietal or visceral

peritoneum, we may say, almost never forms a part of the contents of an infantile hernia, as when it does appear it must contract solid adhesions with the sac, an accident which seldom presents in early life.

Although such adhesions are exceptional, they are not impossible. When they do exist, they generally result from a truss which is badly adjusted, and excites inflammation. It may also be an incident of imperfect immigration of the testicle. The adhesions are less compact and solid than in an adult, sufficient time not having elapsed for fibrous changes to take place.

Though we may meet with the complication in an infant or child or adult, the distended balloon is equally efficacious in those cases, in the operation for their radical cure. The operation is commenced, as in the preceding cases which we have described, the surgeon proceeding cautiously until the neighborhood of the sac is reached. The difficulty now, is to know where we must make the opening. There is danger of cutting at once into an adherent intestine, if we do not alternately reduce and bring the intestine and pick up the sac, independent of its contents, when we may open it without fear.

Sometimes, it is extremely difficult to find the hernial investment. In one of our patients we had to divide successively many laminæ before we reached the hernial cavity. At last, the opening is made, the borders seized and drawn aside with the forceps. The finger enlarges the aperture and engages in the sac, when we recognize the seat, nature and extent of the adhesions.

In children, the adhesions will most commonly be found at the neck of the sac. If they are recent, the finger will easily separate them when reduction is easily affected. It must not be forgotten that the intestine at this early age is exceedingly fragile, and that we should accordingly manœuvre with extreme care. Certainly, if it does not lie in the way of the adhesions, there is nothing to fear.

With the adult, partial adhesions are observed everywhere; at the base of the sac, its sides, at the neck, and above all, in the abdominal funnel, near the internal orifice. The finger

must thoroughly free them all. We now introduce the balloon through a slit in the sac, following its grand axis, engaging its small extremity in the inguinal tract, as close by as possible to the aperture. The balloon now filling and rising without bruising the parts contained, it carries them towards the surface. The surgeon now has under his eyes a tumor of a variable contour, but a consistence as usually encountered on which we practice a dissection and enucleation with as much facility, but a little more reserve, than in more happy cases. It is towards the free parts in the direction of the balloon that we first direct our dissection, its color directing us. It is on this we should depend for a guide and reliance, and then proceed with due care, freeing the adhesions and isolating the pedicle. Without any delay, we push the dissection towards the ring, in the meantime freeing the hernia from below.

There and there only, after having prepared by a dissection high up, we will attain a good result and radical cure. We now slowly allow the air to escape from the balloon, enlarge the slit in the sac superiorly, and fix the borders with forceps. The hernial contents are then examined and returned; the sac being fully and freely opened, we proceed to the liberations of the adhesions. If it is an adult, and the intestine is bound down by the omentum, it should be ligated and cut away; the intestine liberated, trimmed and returned.

When the hernia is free, the finger is carried into the abdomen, to prove that all adhesions at the internal orifice are well loosened. A large forceps then seizes the neck and and draws the peritoneum as low down as we can, so that the catgut may be knotted as high as possible. With a child the introduction of the finger is necessary, as the neck with them is usually the seat of the obstacle. It is an adhesion due to a contusion by the truss, and is remedied without, in operating.

(To be continued.)

CORRESPONDENCE.

LONDON LETTER.

Several disturbing factors have, during the past few months, been rampant, and have seemed to take away a portion of the interest in one's business, and now that politics and the weather are no longer the topics of conversation, the cholera epidemic is the subject which is being eagerly discussed. It has gained a great hold on the continent, and its effect on commerce is serious, particularly at Hamburg.

The Local Government Board of this country has issued voluminous instructions to the several local authorities, and the latter are making unstinted use of chloride of lime, carbolic acid, and other cheap and efficient disinfectants. Great attention is also being paid to the drainage system, and the general belief among medical men is, that the scourge cannot make much headway in England, although imported cases will naturally occur.

Sir Wm. Roberts, M. D., has been delivering some highly interesting lectures before the Royal College of Physicians here, and the matter explained, showed that a vast amount of reading and general research had been brought into requisition to place the lecturer in possession of the knowledge and acquaintanceship with the subjects dealt with.

As one result of his experiments regarding the treatment of gout, he comes to the conclusion that the use of alkalies, such as potash and soda are of minute, if of any real good, because the blood serum is already alkaline, and the addition of soda really hastens the precipitation of uric acid crystals. This, he remarks, is often the effect produced on a gouty patient by drinking alkaline waters.

The subject of cancer has been the subject of a series of lectures delivered by Dr. Britain at the Royal College of Surgeons. He dealt principally with his subject as found in chimney sweepers. It is curious that cancer is quite common among this class in Great Brittin, while in other parts of

Europe it is comparatively rare. Dr. Brittin accounts for this in various ways. In England, sweepers do not take much care as regards personal cleanliness, and they take no trouble whatever, to prevent the soot from reaching their bodies, or even their lungs, while abroad the sweeps exhibit considerable care, as a rule, to keep themselves protected from the soot. To attain this object, on many parts of the continent they wear a peculiar style of dress, generally tight-fitting and fastened round the wrists and ankles by tapes or straps, to leave as little space as possible for the ingress of soot. They also cover their mouths and noses with a cloth, and all these precautions are taken regularly, as a matter of course.

The soot most likely to produce a cancerous condition, is that of the coal known as hard or stone coal.

At the meeting of the British Medical Association at Nottingham, several highly interesting and instructive addresses were given, and among these, Dr. Brookhouse, the senior physician to the Nottingham General Hospital, gave some notes on his treatment of phthisis by menthol. Since the practical abandonment of Dr. Koch's treatment, intra-trachial injection has come more to the front, various substances being used, such as eucalyptus and creasote in castor oil, or aristol in the same medium, but Dr. Brookhouse recommends the simple menthol solution; he injects once or twice daily into the trachea of his patients, one drachm of a twelve per cent. solution of pure menthol in pure olive oil, using a laryngoscopic mirror and an ordinary tracheal syringe. In his cases where this treatment was used, he says that very soon there was marked decrease both of cough and expectoration, the temperature was much steadier and there was a gain in weight, night sweats being lessened or altogether checked. Although, as a palliative measure, menthol may be of great use as a curative agent, the results have not been very satisfactory.

The British Association Conference held in Edinburg was a great success and was very largely attended by members from all parts of the world. The work gone through was very great, and embraced a large selection of subjects. Dr. Louis Robinson gave an interesting lecture on the prehensile power

of new-born infants. He remarked that a new-born child would hold on to his hand and support its weight in the air for a minute and sometimes even thirty seconds longer. He traced this back to a time when it was necessary for the young one to hold on to its parent, and so leave the parent's hands free, as seen in the arboreal apes at present.

The much boasted cure for cancer, perfected by Count Mattei, has come to a hasty termination, now that the report of the committee appointed by the Matteists to watch cases of their selection has been issued. The cure, as many eminent and reputable practitioners supposed, is clearly entitled to be regarded as a swindle, and it is a pity that attempts to dupe those suffering from painful maladies cannot be prosecuted. The defense would probably be that all was done in the interests of science and suffering humanity in general!

DERMATOL IN GYNECOLOGY.—Asch (*Cent. fur Gynecologie; Condensed Extracts*) deems dermatol of comparatively little antiseptic value, but owing to its decided siccative action, he considers it indirectly useful in further aseptic healing of wounds.

He prefers it to iodoform in lacerated cervix after suture, but not in inoperable ichorous carcinomata. In recent ruptured perineum and in perineoplasty, he considers it most desirable, as it protects the wound and sutures from saturation and uncleanliness better than any other remedy. A single application of a thick layer of dermatol, loosely covered with dermatol gauze, will keep the site of operation dry and clean for a several days.

The author reports success in vaginal catarrh from using dermatol tampons.

In an extensive ulcer of the portico vaginalis and of the fornix he obtained rapid healing with dermatol.

In intertrigo, one or two applications of a thick layer of dermatol sufficed to produce marked improvement.

Dermatol is recommended as a protective dressing for the healthy skin, when using irritant substances upon a diseased point.—*Annals of Gynecology.*

Society Notes.

CLINICAL SOCIETY OF MARYLAND.

BALTIMORE, MD., May 20, 1892.

The 267th regular meeting was called to order by the President, Dr. Robt. W. Johnson.

DR. H. O. REIK, 1525 N. Caroline St., Baltimore, was elected to membership.

DR. SAMUEL THESBALD related "A Case in which the Electro-Magnet was Employed Successfully for the Removal of a Fragment of Steel from the Vitreous Chamber of the Eye."

A lad, of 12 years of age, while using a hammer, struck a small piece of steel, which penetrated the eye and lodged in the vitreous chamber. The case was first seen six days after the accident. The fragment penetrated the upper margin of the cornea, and just in line with this was a hole through the iris as large as a small pin's-head. The eye was markedly injected with evidences of, perhaps, commencing iritis. In vitreous humor, diffused opacity and numerous floating opacities. There was a punctate opacity on the anterior surface of the lens where it had been touched by the foreign body. Details of fundus could not be seen. The foreign body was not visible. Vision, 16-125ths. Operation five days after the patient was first seen or eleven days after the accident. The injection increased and iritis had begun. Incision abont 4 m. m. in length through the sclerotic between the external and inferior rectus muscles. A Hirshberg's electro-magnet was employed. A single cell of the battery was used; this enabled the magnet to lift up a tack hammer. The point of the magnet was introduced well into the vitreous humor three or four times without success, but finally it brought out the little particle of steel, the size of a pin's-head. The conjunctival wound was stitched, and an opium and boracic acid lotion with compress was used. Atropia kept the pupil dilated. Boy suffered very little. Seventeen days after the operation

he left the hospital, at which time the injection was very much less, the vitreous had cleared up very materially and vision was 16-45ths. At the present time, forty-four days after operation, the fundus of the eye can be seen with perfect ease. There are one or two floating opacities in the vitreous humor Vision 16-30ths.

DR. ROBERT RANDOLPH: This case is one of a very large class, forming the larger number of cases which come to us for enucleation, and the larger number which end in sympathetic opthalmia. We have there a better method of dealing with such cases. When we have a reasonable idea of the location of the foreign body, and under strict antiseptic precautions, the operation is indicated, and there are a sufficient number of cases on record to justify us in looking for a happy issue.

DR. KATE CAMPBELL HURD read a paper on "Treatment of Spinal Curvature by the Zander Method."

DR. J. H. BRANHAM reported a case in which "A Sea-Tangle Tent was Forced into Douglas' Cul-de-sac in an Attempt to Produce Abortion."

On February 27, 6 P. M., saw in consultation a young married woman of 24, mother of three children. She had been about two months pregnant and had attempted to produce abortion on herself with a sea-tangle tent three days before I saw her. After leaving it for twenty-four hours, she tried to remove it, but simply pulled out the string. Next morning her physician was summoned, but failed to find the tent, although the uterus was partly dilated, and from it issued a bad smelling discharge. When I saw her, her temperature was 103, pulse 120, abdomen very much swollen and exceedingly tender. The finger could be introduced into the uterine cavity, but no tent was found. An opening in the wall of the cervix was discovered, and through this the tent was felt in Douglas' cul-de-sac. It was removed through this opening, and was found to be about the size of one's little finger. An opening was made into the cul-de-sac, and a drainage tube put in. The uterus and vagina were washed out with 1-4000 bichloride. There was a temporary improvement, but she finally died, thirty-six hours after I first saw her.

The woman maintained to the last that she introduced the tent herself, and this is probably true, considering the direction in which it was forced.

W. T. WATSON, M. D, Sec'y.
1519 N. Broadway, Baltimore, Md.

TREATMENT OF CORNEAL SPOTS.—(*Bollettino d'oculistica*, February 15, 1892.) Small dots of opacity of the cornea can be seen in their normal type when the evolution of the repairing process takes place in a natural manner and without the employment of any kind of treatment. When a spot of more or less thickness is formed by the union of the cicatricial tissue of the deposits of conjunctival secretions with the hypertrophied epithelial masses, we can endeavor to restore to the cornea, its transparency, by the transformation of that opacity into a sore or an ulcer. The author of this excellent article, Dr. A. Simi, is of the opinion that preference should be given to caustics to attain the desired result, and of all of them, he chooses iodide of potassium in a concentrated form. He considers it more suitable than citric acid, on account of its dissolving action when applied to calcareous depositions as well as to epithelial masses.

The clinical case reported by the author is entirely conclusive, because the leucoma treated by this method, which had entirely abolished the visual function, was cured without leaving the least trace on the cornea. The *modus faciendi* of the treatment is the following: the applications are practiced every day with a fine brush moistened with the solution, and previously passed over a crystal of citric acid. They are continued until the complete clearing out of the opacity occurs. Strict antisepsis has to be observed during the entire course of this treatment, which is a long one, the healing taking place very slowly, and sometimes it is necessary to prolong it by making new cauterizations.—*Inter. Med. Mag.*

Book Reviews.

ANNUAL OF THE UNIVERSAL MEDICAL SCIENCES.—Edited by Chas. E. Sajous, M. D., and seventy associate editors, assisted by over two hundred corresponding editors, collaborators and correspondents. Five volumes. Published by the F. A. Davis Co., Philadelphia, 1892.

BUT few changes have been made in the general appearance and make-up of the fifth series from those of the preceding years. The general character of the articles, together with the corps of collaborators presented, indicate with what earnest endeavors the editors are striving to maintain that high degree of excellence which has characterized it since its first appearance. The Annual is yearly enlarging its scope of usefulness, and through the tireless devotion of its excellent editorial staff, among whom, we are pleased to note our colleague and fellow townsman, Prof. J. McFadden Gaston, who contributes a paper upon Thoracic Surgery, the publishers hope soon to witness its evolution into the state of perfection which has ever been its aim to reach.

C. E. J.

BOOK ON THE PHYSICIAN HIMSELF, AND THINGS THAT CONCERN HIS REPUTATION AND SUCCESS.—By D. W. Cathell, M. D. New tenth edition (author's last revision). Thoroughly revised, enlarged and rewritten. In one handsome Royal Octavo volume. 348 pages. Bound in extra cloth. Price, post-paid, $2.00, net. Philadelphia: The F. A. Davis Co., Publishers, 1231 Filbert street.

A BOOK, without which the library of every young physician is incomplete; one which the "younger members of our profession and also the older ones who have paused at less than the average degree of success in life," should especially read, but which will be found by all true worshippers at the shrine of Æsculapius to be replete with advice upon the many little points connected with the practice of medicine, a thorough knowledge of which is so necessary to his success.

C. E. J.

THE SCIENCE AND ART OF MIDWIFERY.—By Wm. T. Lusk, A. M., M. D., N. Y. D. Appleton & Co., 1892.

IT IS not necesssry to go into a strict review of a book so well known to the profession as this work of Dr. Lusk's, which now appears in its fourth edition.

The author has revised some of the principles taught in the former editions, thus bringing the work fully abreast with the latest researches on all subjects pertaining to the subject-matter. He heartily endorses strict adherence to aseptic and antiseptic midwifery as carried out in the principles of modern surgery, without any of the pedantic measures that have proven useless.

Chapter XVII. is devoted entirely to the subject of extra-uterine pregnancy and deserves a careful perusul by all who feel that they are not conversant with this subject that has of late attracted so much attention.

The book is neatly gotten up and deserves a place in every library. W. A. C.

DISEASES OF THE NERVOUS SYSTEM.—By Jerome K. Bauduy, M. D., LL. D., Professor of Diseases of the Mind and Nervous System, and Medical Jurisprudence, Missouri Medical College, St. Louis; late Physician in Chief to St. Vincent's Institution for the Insane; corresponding member of the New York Society of Neurology and Electrology, etc. Published by J. B. Lippincott Co., Philadelphia.

PROFESSOR BAUDUY has completed quite a number of quotations and formulated them into a book, adding a few italics as the author's own, and in doing so, we fear, has not done himself justice, for we think he could have done better had he given his knowledge to the world, as many others have done and with credit to themselves in the form of clinical lectures, where he could have better displayed his knowledge, unaided by quotations.

This review would not be severe, but only attempts a suggestion to those ambitious authors: that rather one original suggestion, or discovered truth, than all the world of known facts or hypotheses, enclosed between the backs of a volume of many pages, for it is well known that a book does not make fame, or add to the knowledge of the reading world unless it contains new facts or suggestions. H. H.

Selections and Abstracts.

COMMUNCIATION ON THE TREATMENT OF CHRONIC GONORRHŒA. (Beitrag zur Behandlung des chronischen Trippers. *Archiv. fur Dermatologie und Syphilis*, 11. Heft, 1892.) By Dr. T. Trzcinski, Warsaw.

This author, after careful observation of many cases, has come to agree with the statistics of Letzel, that ninety-two and a half per cent. of all gonorrhœas become posterior and last for many months in spite of any treatment. He is inclined to put but little stress upon the presence of stricture as being the prominent factor in keeping up a discharge in the more recent cases, but advises in all old cases, that the urethra should be carefully examined and all contractions be removed. As regards local treatment, he objects to the methods of Guyon and Ultzmann as being unscientific and too severe in most cases, while the application of medicaments in the form of suppositories and salves, he considers even worse. His faith in the urethroscope is exceedingly limited, and he boldly states that the theories in regard to urethral pathology presented by Grunfeld, are preposterous. The method which he advises is a modification of that of Neiser, and consists of the daily washing of the entire urethra with a solution of one to eight thousand and gradually increasing up to one to three thousand, using a small catheter with an olive tip, which is passed gently into the bladder and the solution introduced by means of a hand-syringe. The first portion of the solution, that washing the posterior urethra, flows into the bladder, the catheter being gradually withdrawn until the compressor urethræ muscle is passed, when the fluid runs out alongside of the catheter, washing the entire anterior urethra. Under this treatment the discharge disappears in a few days, leaving only "tripperfaden" (gonorrhœal threads), which may continue for some weeks. A patient may be considered cured when he can squeeze out a drop containing no pus, and when only a few "tripperfaden" exist in the morning urine alone.—*Amer. Med. Mag.*, Sept. 1892.

CHANGE OF AIR AND BATHS IN THE SUMMER DIARRHŒA OF CHILDREN.—(*Medical News*, June 18, 1892.)—Dr. Simon Baruch points out the advantages of change of air for relieving the disorders due to high temperatures, marked atmospheric humidity, and vitiated atmosphere. The floating hospitals and sea-side sanitariums conducted by the St. John's Guild, the Babies' Shelter and other charities furnish thousands of children in New York with the opportunity to escape for a day or longer, from the depressing influence of hot and impure air. Dr. Baruch says, "While for reasons already mentioned, a change is imperative in almost all cases of summer diarrhœa of the children residing in crowded tenement-houses, it is not so important in those cases whose environment is more favorable for home treatment. Indeed, the change from a comfortable home to a country hotel which is apt to be over-crowded, is not to be advised without careful reflection. It is not an infrequent occurrence to order a sick child away, when the symptoms become alarming, without time for preparation or due inquiry. The consequences are discomfort from immaturity of plans, great expense, disturbance of the family, and consequent anxiety and unhappiness for the parents and friends. Before deciding that the benefits which are likely to accrue to the little patients warrant these measures, it is imperative to be satisfied that we have exhausted all other methods of treatment, particularly sterilization of food and intestinal irrigation." Explicit directions are given as to bathing and the use of the wet pack. These measures ought to be more freely adopted.—*Inter. Med. Mag.*

INOCULATION AGAINST CHOLERA.—Haffkine having found by recent experiments that anti-cholera vaccine prepared after Pfeiffer's methods had the same action on various sorts of animals, ventured to try the inoculation himself. He injected subcutaneously in his left side a larger dose than that used in animals, of the so-called first kind of anti-cholera vaccine. The indisposition which followed lasted twenty-four hours, and consisted of a rise of temperature of 1 degree C., with headache, dryness of the mouth, and clouding of the urine, with no disturbance of the digestive tract. Locally there

was pain, slight swelling, and glandular enlargement. The pain lasted five days. The swelling gradually diminished and disappeared on the ninth day. Six days after the first inoculation, Haffkine had the other side inoculated with the strengthened cholera virus (vaccine No. 2). Again there was a rise of temperature and local pain, but no swelling. The general condition was normal in twenty-eight hours, and the pain disappeared in three days. There were no digestive disturbances. The inoculation was tried in three other persons with similar results. In one of these cases a slight diarrhœa, which had lasted for several days, stopped the day after the first injection. The inoculation of both kinds of anti-cholera vaccine, the protective power of which in animals has been experimentally proved, is harmless to men, and Haffkine entertains the hope that six days after inoculation with this vaccine, the human organism will have obtained complete immunity against every cholera infection.—*Ex.*

THE PIN SENSATION IN THE THROAT.—(*New York Med. Jour.*, June 11, 1892.)—Dr. John Dunn reports five cases of the above condition. In the first case reported at some length, the patient had the sensation of a pin in the throat on swallowing. The sensation was referred to the right side, on a level with the deepest part of the hyoid fossa. After treating various conditions without effect, touching a small red elevated area at the back of the pharynx was found to cause the sensation. An interesting point was that this spot was described as lower down than various points really below it. Galvano-cauterization gave relief only while the wound was healing. The second patient had a similar sensation on the on the left side of the throat caused by a small somewhat inflamed "granulation" above the enlarged left tonsil. The other three cases were all caused by small hypertrophied masses of lymphoid tissue in some part of the pharynx. The interesting point in all these cases is the fact that the patients all erred in placing the cause of the sensation lower than it really was. Treatment appears to have been successful in all but the first case.—*Ex.*

DUTIES OF MIDWIVES, NURSES, AND HEALTH-OFFICERS, AS DEFINED BY THE LEGISLATURE OF RHODE ISLAND.—*Duties of midwife or nurse.*—Section 1. Should any midwife or nurse, or person acting as nurse, having charge of an infant in this State, notice that one or both eyes of such infant are inflamed or reddened at any time within two weeks after its birth, it shall be the duty of such midwife or nurse, or person acting as nurse, so having charge of such infant, to report the fact in writing within six hours to the health-officer, or some qualified practitioner of medicine, of the city or town in which the parents of the infant reside.

Duties of Health-Officer.—Section 2. Every health-officer shall furnish a copy of this act to each person who is known to him to act as midwife or nurse in the city or town for which such health-officer is appointed, and the Secretary of State shall cause a sufficient number of copies of this act to be printed, and supply the same to such health-officers on application.

Penalty.—Section 3. Every person who shall fail to comply with the provisions of this act shall be fined not exceeding one hundred dollars, or imprisonment not exceeding six months, or both.

Section 4. This act shall take effect, July 1, 1892.—*Ex.*

TREATMENT OF UTERINE HEMORRHAGE.—Routh (*Practitioner*, July 1892, p. 5) recommends that in case of profuse menorrhagia, and especially if metrorrhagia is also present without obvious cause, the cavity of the uterus should be explored. The best means of exploration is rapid dilatation of the cervix with graduated bougies, under anesthesia. With rigid antisepsis there is practically no risk and rarely consecutive pyrexia, unless malignant disease or salpingitis be present. Even if tubal disease is present or suspected, exploratory dilatation of the cervix for hemorrhage of apparently intra-uterine origin is not necessarily contra-indicated, salpingitis often being secondary to and aggravated by intra-uterine disease. If fibroids of the uterus are evidently present, the immediate cause of the hemorrhage may be a removable one, such as co-existing polypus or fungous endometritis. The

uterine cavity should therefore, when practicable, be explored before removal of the appendages or hysterectomy is considered. In some cases, dilatation alone suffices to relieve hemorrhage and pain. If exploratory dilatation were more commonly adopted prior to the employment of Apostoli's treatment, it would lead to a more exact knowledge of the applicability of the latter and place its use on a more scientific basis.—*The American Practitioner and News.*

INJECTIONS OF TESTICLE JUICE IN TUBERCULOSIS.—Espagne and Pourquier (*Nouv. Montpellier Med.*, June 4, 1892) have tried hypodermic injection of testicle juice in a case of pulmonary tuberculosis. The patient was a girl, aged eighteen, without known hereditary antecedents, but of lymphatic temperament. There was harsh breathing nearly all over the chest, and dry crackling at both apices, especially on the left side and at the back. The girl suffered from amenorrhœa and profuse night-sweats, and was wasting steadily. The testicle juice was prepared as follows: 50 grams of testical substance (from a bull calf) were macerated for twenty-four hours in 50 grams of sterilized glycerine. This preparation, after filtration first through paper and then through a Chamberland filter, gave a clear liquid almost as transparent as distilled water. The injection of a Pravaz syringeful of this liquid caused considerable pain, but was followed by a fall of temperature and reduction in the pulse-rate. The authors, however, are doubtful whether a repetition of the injection will be permitted.—*British Medical Journal.*

HEADACHE DURING CHILDHOOD.

Seven groups of headache may be classified:

1. Headache from rapid growth. It is usually frontal, is increased by exercise, and co-exists with pain in the joints, periostoses, and hypertrophy of the heart. Treatment: muscular repose, tonics, liberal diet, phosphate of lime, malt beer

2. Headache from intellectual activity. It occurs in intelligent and excitable children, who study too much; or in backward children, who acquire their lessons with difficulty.

Treatment: for the first class of cases, cessation of intellectual work, physical exercise, but not so severe as to produce fatigue, luke-warm baths. In the second class of cases, the work may be continued in moderation, plenty of exercise being enjoined.

3. Headache from digestive troubles. It occurs in children who eat too much or too fast, and occurs in one to three hours after eating. Treatment: properly regulated hygiene and diet; by bitter tonics before eating, warm drinks after eating. Constipation should be overcome.

4. Headache of nervous origin. It occurs in children who are excited by their manner of living. It is premonitory of future neuropathies, epilepsy, and hysteria. Treatment: baths, walking, massage, valerian, aconite, and antipyrin for the hysterical; belladonna and bromides for the epileptics. They should avoid taking cold.

5. Headache in children of gouty or rheumatic diathesis. It is sometimes accompanied by intense congestive phenomena, which simulate meningitis. There are manifestations of hereditary antecedents; there are neuralgias, arthralgias, myalgias; the urine contains phosphates, oxalates, and urates. Treatment: moderate diet, exercise in the open air, vapor baths with friction, laxatives, alkalines, salicylate of soda in doses of from twenty-five to thirty centigrammes, and tincture of colchicum in ten to fifteen drop doses daily.

6. Headache from anæmia and poisoning. In the first case it is due to bad air and hygiene, in the second to malaria, carbonic oxide, to excessive medication, to uræmia. Treatment: it should vary with the cause.

7. Headache from injury to the sensory organs. There may be chronic conjunctivitis, or keratitis, or iritis, which should be treated locally, and also by the internal use of sulphate of quinine in large doses. Troubles of refraction, hypermetropia, and astigmatism must be treated with suitable glasses. There may be mucous polypi in the nose, or hypertrophies, which call for local treatment. There may be adenoid vegetations in the ears, otitis, or foreign bodies in the auditory canal, which call for suitable treatment.—*Archives of Pediatrics*; *Abstract and Index.*

OVER-PRESSURE IN CHILDREN, CAUSING BRAIN MISCHIEF.

BY J. A. DIGGLE, L. S. A., LONDON.

The following cases show the inadvisability of attempting to force children forward in schools without sufficiently considering their different individual capacity for learning.

It is, I am afraid, much too common a cause of children's ailments nowadays, and has not been quite enough considered, I think, by parents and teachers. In the ordinary Board School, as at present constituted, every child in each standard must be pushed on, *pari passu*, with all the others, so as to get all, if possible, passed at the examination next ensuing, into the standard above. In the first case here noted, the fault, *fons et origo mali*, was with the parents in sending such a young child to school at all, but as both parents were factory workers, and there was only a slightly older boy besides, the child went to school with him.

Both cases were very similar in the outset, but the first was the most severe, and in both I thought at first the illness was enteric fever, the more so as being next door neighbors and residing on the banks of the river, which is very foul and much polluted, and on Sundays, when the water is low, great banks of festering abominations are exposed.

Case I. Alf C., a sharp and more than usually intelligent little boy of only four years and eight months, was seized on April 3d, at breakfast time, with sickness and pain in the head. He had been attending school for six months, and being naturally quick, as I have said, he had been encouraged to learn, and had already reached the final class in the infant department, and would have been put into the general school but for his age, which forbade it.

When I saw him at 11 A. M., he was in bed, slightly flushed, head very hot, and temperature 99.2 degs. Tongue rather foul. Complains of pain in the head, and avoids light. No further vomiting since breakfast. Gave him a mixture of potass. citrat and tinct. aconiti and calomel, gr. j., with sugar.

April 4th. Passed a bad night, rambling and talking about

school. Tongue rather cleaner. Temperature 99.4 degs. Milk diet. To continue mixture. Night temperature same as morning. Added k. br. gr. ij., aa dose to medicine.

5th. Night passed much the same as last. Lies very quiet and still, but easily roused, and then quite conscious. Temperature 100.2 degs. Thirsty. Tongue furred but moist. No pain in abdomen. Stool natural. Ordered antipyrin, grs. v. every three hours. Temperature at night, 100 degs. Been delirious all afternoon. Ordered ice-bladder to head.

6th. Rather better this morning. No diarrhœa. No spots on abdomen. Head, however, very hot, mother having taking off ice-bag at 4 A. M., as child slept. To be replaced. To have five mins. bromidia (Battle) every two hours. Temperature, 100.2 degs.; night temperature same.

7th. Much better. Fairly good night. Slept four hours; tweve midnight to four A. M. Playing with toys on bed when I saw him. Temperature, 99.2 degs. Tongue cleaner. To continue bromidia mixture.

8th. Not quite so well. Ice-bag again neglected, to my vexation. To be continued, as also mixture.

9th. Much better. Sitting up playing. Temperature, 99 degs. Ice-bag discontinued. Same mixture.

10th. Improving fast. Not much appetite. Quin., gr. 1-2, s. t. d.

11th. Up and dressed. Still improving. No headache or pain. Temperature normal. With the exception of a slight cough, all went on well until 14th, when I discontinued visiting.

The good effect of the ice and bromidia was very quickly apparent in this case, as also in the next.

Case II. John B., a strong, sturdy, rough lad of just over 7 years of age, was a contrast to A. C., in that he was anything but fond of lessons, and rather dull in all subjects except drawing, in which he excelled.

He had failed last year in the examination, and in consequence, his teacher had been urgent as to the necessity of his passing this time, and had been, perhaps, rather too sharp on the lad.

Just a fortnight before the examination, on April 21st, he

was seized also at breakfast time, with vomiting and pain in the head.

When I saw him in the forenoon, he was lying on a bed-chair, very drowsy, and resenting being roused. Had vomited every few minutes since breakfast, at which he had only drunk a cupful of coffee. Head very hot. Pupils contracted; buries his face in the pillow. Temperature, 100 degrees.

Ordered cold water cloths to head until ice-bladder could be got, and a potass. citrat. mixture.

April 22d. Sickness relieved. No delirium, but wanders when roused, and talks of his play. Ice to head. Bromidia, m. v., every two hours. Night much the same. Temperature, 100 degrees.

23d. Much better. More easily roused, and sensible, though when left to himself, lies quiet for hours. Temperature, 99 degs. To continue bromidia and ice.

24th. Better. Sitting up in bed with his drawing-book. No dullness or drowsiness. Complains of no pain at all. Appetite not good. Quin., gr. 1-2, t. d. s.

25th. Appetite improved. No bad symptoms. Temperature normal. Playing about the bed-room.

26th. Ceased visiting. Boy going on well.

It seems curious to me that two lads of opposite temperaments should be so similarly affected. One sharp and intelligent, though very young and not compelled to learn; the other older and duller, probably harassed by his teacher, and yet both develop almost the same symptoms. I may say that the younger child, a fortnight after I ceased seeing him, had a regular hysterical fit because his mother would not allow him to go to school with his brother, and was in a state of collapse, cold and pale, for two or three hours after.

The rapid improvement under the ice and bromidia treatment was very gratifying, and I have found bromidia very useful in such cases, and a reliable hypnotic whenever I have required to prescribe such a medicine.

1 Dane Street, Rochdale.—*The Hospital Gazette.*

Editorial.

EPIDEMIC CHOLERA.

At one time there seemed no doubt of cholera gaining a foothold in the United States, for the most rigid quarantine measures that any American port has ever exercised have heretofore proved ineffectual, and seven deaths did occurr in New York city. These deaths occurred in different sections of the city, and how the persons dying became infected with the disease we know not. We only know that in some manner the agent carrying the specific cause of the disease passed quarantine, and that quarantine regulations proved ineffectual in preventing its advent, although they may have prevented an epidemic at the present time by arresting a large number of persons who would have proved centers of infection. Whether quarantine regulations will prevent the occurrence of an epidemic next spring is the question. Cholera may be introduced into this country in three ways: first, by passengers who are apparently in good health, but who in reality contain cholera germs; second, by provisions; and third, by freight, such as hides, rags, etc.

Quarantine has no doubt prevented the introduction of the disease by the landing of infected passengers, for we can trace no case as yet to any one who has passed through quarantine; but can quarantine prevent the introduction of cholera germs in provisions, and ship-freight brought to this country? A vessel without a single case aboard when it lands, and with no history of disease on its passage, yet may have the germ of the disease in its freight, and when this freight is handled in landing, and shipped to its final destination (which may be some inland town instead of a seacoast city,) then the germs which have lain dormant during the voyage, because the cargo has not been handled by the sailors, may find the proper soil for its culture and prove a center of infection. It is impossible to disinfect large cargoes of freight so thoroughly that all germs of disease will be destroyed-

If quarantine is kept up for eight or ten months, and all importation is prohibited, then it may be possible that the cholera can be kept away, but as soon as strict quarantine is relaxed and importation is allowed, the germs of cholera will surely be introduced.

The seven sporadic cases of cholera in New York city have been caused, no doubt, by poison which passed into this country in this manner, and probably before the quarantine regulations were vigorously enforced. We trust that no more cases will occur, but we have the dread of an epidemic in the future, and we will from now on have to guard against anything that may prove favorable to its origin. Sporadic cases can occur in clean, healthy neighborhoods, but bad local conditions are necessary for epidemics. Water is the chief means by which the disease is spread. One infected well or spring may cause hundreds of cases, and the water supply of Atlanta, infected by drainage into the reservoir from its water shed of the choleraic discharges of one person would cause an epidemic that would decimate the city. Too much attention cannot be paid to the water supply, cleaning of all the streets, alleys, backyards, sewers, and low places, for the only thing that will bring absolute immunity from epidemic cholera will be the purest water and the strictest cleanliness.

A most important step to take in preventing epidemics, especially Asiatic cholera, is to dispose properly of the dead. The few cases that have died in New York have been buried in hermetically sealed metallic caskets. This, in my opinion, is only prolonging the evil. I have seen several of these caskets exhumed, and all of them had been burst by an expansion of the gases due to decomposition, thereby allowing an escape of the fluid contents. The metallic casket is likely to do more harm than good by giving a fancied security, when if a wood casket had been used it would not have been. It is possible that graveyard drainage may infect the water supply. In fact, Dr. John G. Lee, of Philadelphia, says, "Burial in the soil within and near our large cities pollutes the earth, the air and water; the earth has no time to destroy the germs of contagious diseases, and the air and water are, when infected, active agents in their propagation."

Three cemeteries of Philadelphia, containing 80,000 graves, are so situated as to render it possible for them to drain into the Schuylkill river which furnishes drinking water to more than one million of people, therefore, it is possible that in our cemeteries we may have a continuous source of infection. We should find other means than inhumation for the disposal of the dead, and if not in death from ordinary diseases, certainly in death from contagious and infectious diseases.

In cremation, we have the only real scientific method, and the only method that removes forever all fear of further danger from any body dying of a contagious or infectious disease. The dead from cholera in Buenos Ayres, during their last epidemic, were cremated, and cremation was made compulsory during the epidemic, which was a small one, nearly a thousand bodies being cremated.

It is customary in some cities to have their pauper dead, and those dying during epidemics, buried in pits about eight feet square and twelve deep, putting ten or twelve bodies in one pit, and allowing the pit to remain open except for a few inches of dirt thrown over the upper layer of coffins, until the required number of bodies have been placed therein. This practice cannot be too severely censured, for it must prove a prolific source of disease, whether the bodies are of infectious diseases or not. Only last fall, I saw five cases of typhoid fever in one house at the same time, and no cause could be found unless it was the well-water which ran from the direction of a fat graveyard on a slightly higher elevation and only eighty yards off. This stream of water ran along a lime-stone formation which lay under the graveyard and slanted in the direction of the well, the soil above being a light sandy loam and very porous.

To prevent an epidemic of cholera, all bodies dying of the disease should be at once cremated, and if this is done while we have only a few sporadic cases, and these sporadic cases are isolated as soon as the disease is recognized, then we may, by this vigorous means, stamp out the poison before it has gained strength enough to rise up and cause a mighty epidemic.

HIGHER MEDICAL EDUCATION IN THE SOUTHERN STATES.

The circular recently sent out from Nashville, with the names of Drs. W. T. Briggs and W. D. Haggard, invites the medical schools of the South to a convention in Louisville, Ky., during the session of the Southern Surgical and Gynecological Association which will be held on the 15th, 16th and 17th of November, next.

The object of this conference is to adopt an uniform standard of requirements by all the Southern schools, and thus place them on an equal basis before the students who may seek a place for pursuing their studies. Without co-operation in the requirements for graduation, it is evident that nothing can be accomplished in advancing the cause of medical education either by lengthening the term, defining the preliminary qualifications, or exacting a thorough knowledge of the different branches for receiving the degree of M. D. Should the schools of one State require a three years' course of study, while others decline to do so, the most probable result would be, that students who are anxious to get a degree by the shortest route, without reference to a high order of professional attainments, should patronize the schools having a two years' course. Had the proposed bill before the legislature of Georgia become a law and exacted from the schools of this State a requirement of three years' attendance on the part of the students, it must have proven suicidal to the Georgia medical colleges, while colleges of other Southern States continned to graduate students with only two years' attendance. The example of the medical college of South Carolina at Charleston in establishing a three years' course, serves to illustrate this point in a most signal manner. If the great falling off in numbers, which has followed this premature step, does not suffice to convince those in authority in Georgia of the fate which must have attended a requirement of three years in advance of the other schools in the South, no reasoning can avail to satisfy them.

However desirable it may be to raise the standard of medi-

cal education, the question of expediency in undertaking to advance the requirements without co-operation, stares us in the face; and if all can be induced to move together by such action as is proposed in this convention, the interests of all concerned will be promoted.

The Southern Medical College has signified its acceptance of the invitation to join in the convention at Louisville, and it is to be hoped that every Southern school may accede to the proposition to adopt a three years' course and insist upon proper preparation for entering upon the study of medicine.

Some definite understanding should also be reached in regard to the qualifications for graduation, so that a wholesale granting of diplomas shall discredit the school which tacitly, if not publicly, gives all applicants to understand that they will receive their degree.

It is not enough that the graduates of such a school shall fail to pass the examination of the medical boards in a neighboring State, however humiliating this may be to the poorly trained victim, but the school discharging such material upon the suffering people of this country should be held to accountability.

The faculty of the Southern Medical College have sought diligently to eliminate the chaff from the wheat in the final examination of students; and the small percentage of failures in the examinations before the Alabama Medical Board, in comparison with those of another school in Atlanta, gives assurance to the public of the faithful work done by the professors of the Southern Medical College in the past, and affords a guarantee of what may be expected in the future. With a commodious new building for the session which opens October 4, and valuable additions to the corps of instructors, it is expected that advantages will be presented to students, equal, if not superior, to those afforded by any medical college in the United States.

While some of the chairs have been vacated by the former incumbents, they will be ably filled by newly elected professors.

Dr. W. S. Elkin has been elected to the professorship of operative surgery, and his recognized ability gives him a just title to this position.

Dr. Floyd W. McRae, who is well and favorably known in this section, has spent much time in attending the polyclinics of New York, and is eminently fitted for his professorship of physiology.

Dr. Henry R. Harris completed his medical education in the Jefferson School of Philadelphia, and afterwards pursued a regular course of instruction in laboratory work, thus gaining knowledge which qualifies him fully for the chair of chemistry to which he has been elected.

Dr. Logan M. Crichton, having established a reputation in diseases of the nose and throat, fills all the requisites for instruction in this department to which he has been elected.

Dr. C. D. Roy, after serving as the assistant to the professor of diseases of the eye, ear, nose and throat, has been perfecting his studies in his specialty in Europe, so that he will meet satisfactorily the full measure of expectation for the chair of eye and ear diseases.

Dr. L. B. Grandy, whose proficiency and skill has already been shown by his work, has been assigned the position of demonstrator of anatomy.

Nothing is requisite to be said in regard to the former members of the faculty of this institution, who still continue to discharge the duties of their several professorships, as they are known of all men to be competent and faithful in their work of instruction.

This reference to the Southern Medical College is intended to put all upon notice that its professors are determined to maintain the position of progressive medical teachers, and that they are now ready to move forward with the co-operation of the other Southern schools, in elevating the standard of medical education. J. McF. G.

The meeting of the Southern Surgical and Gynecological Association, in Louisville, has been postponed from the 8th, 9th and 10th until the 15th, 16th and 17th of November. It was thought wise to change the time of the meeting from the fact that the 8th of November is the date of the Presidential election. Everything points to a very successful session.

TO OUR READERS.

As will be seen, we present to our readers this month a London letter, which is full of interest and gives in a graphic style the news of that great metropolis. We have completed arrangements whereby we will be enabled also to publish a regular New York letter which will be fuller and more complete than those of the past.

We also offer this month some premiums, which will be found by turning to our advertising pages. It is our purpose to keep thoroughly abreast with the times, and from time to time, will add any new features which will be found advantageous to our readers.

Dr. Thos. F. Wood, of Wilmington, N. C., editor of the *North Carolina Medical Journal*, died suddenly on August 22nd, of aneurism of the aorta in its ascending portion. He was a man who enjoyed the respect and confidence of his colleagues, and up to his death did a very extensive practice. He was also Secretary of the State Board of Health, and a member of the Committee for the Revision of the Pharmacopœia. The profession has lost a brilliant light, and the public a benefactor.

The Mississippi Valley Medical Association will hold its eighteenth annual session at Cincinnati, Wednesday, Thursday and Friday, October 12th, 13th and 14th. The program is a valuable one, and covers every department in medicine.

SALOL IN CHOLERA.—The treatment for cholera proposed by Dr. Lœwenthal (a dose of two grams followed by hourly or half-hourly doses of one half to one gram of salol), after experimenting with it in the laboratory and on animals has been used on human beings with remarkable results. Dr. Gonzales, of Salvador, has used this treatment in fifty-three cases of cholera in one of the Phillipine Islands with only three deaths (and these were already in the last stages of the disease when they came to treatment). The mortality under other modes of treatment is about forty-five per cent.—*Ex.*

Special Notes.

SANDERS & SONS' EUCALYPTOL EXTRACT (EUCALYPTOL). Whenever mention is made of "Oil of Eucalyptus" we beg you to bear in mind that such reference applies to our preparation, styled for distinction, "Eucalypti Extract (Eucalyptol.)" To avoid disappointment we would suggest to specify, when prescribing, our manufacture. Samples gratis through Dr. Sanders, Dillon, Iowa. Meyer Bros. Drug Co., St. Louis, Mo., Sole Agents.

ADVERTISING.—If you wish to advertise anything anywhere at any time write to Geo. P. Rowell & Co., No. 10 Spruce St., New York.

Of Pepsins and Pepsin-making there is apparently no end. The rivalry between the larger firms in the manufacture of digestive ferments has resulted in the abolishment of old standards and the adoption of more advanced standards both of digestive power and of general excellence.

The recent introduction of Webber-Pepsin, S. & D., by Sharp & Dohme, of Baltimore, Md., with unequalled digestive power of 1 to 6000, certainly marks this as a truly progressive age. But when we consider the possibility of a pepsin of five times this power, or, in other words, one that will digest 30,000 times its weight of coagulated egg-albumen—and this phenomenal power has actually been accomplished by Sharp & Dohme—the Webber process seems to be a veritable Aladdin's lamp.

During the past year we had under our care a young lady, the daughter of the mayor of a neighboring city, whose life was being greatly marred by a painful affliction of the eye which had baffled the skill of several of the leading oculists of this country and Europe. It was finally decided to be due to a peculiar uterine condition. Only a few such cases have been known. She was altogether cured of the trouble, which had existed for over four years, by tablets of Ponca Compound.—*Ed. Mass. Med. Journal*, Boston.

A Voice from the South.

THAT a greater variety of valuable **Medicinal Plants** are found i
the **Southern States** than in any other section of this country, i
a fact known to all physicians who have taken the pains to investigat
the sources of our drug supplies. In fact, the South will hold her ow
in this respect, with any other section of equal area in the world. Sh
furnishes the principal laboratories of our own country with the bul
of their crude drugs, and even foreign manufacturers draw largely o
her fields and forests for supplies of many valuable medicinal agents no
found elsewhere. It is, therefore, not surprising that the discovery of
remedy that promises to revolutionize the treatment of Chronic or Co
stitutional Disease
(such as Syphili
Scrofula, Rheumatism
Eczema, etc., etc.,) i
announced from th
quarter. The stor
of this discovery i
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VOL. XXII. ATLANTA, GA., NOVEMBER, 1892. No. 11

Original Articles.

THE USES AND ABUSES OF COCAINE, WITH REFERENCE TO MUCOUS MEMBRANES ESPECIALLY.*

BY ARTHUR G. HOBBS, M. D., ATLANTA, GA.

Ex-President of the American Rhinological Association, Member of the American Medical Association, of the Georgia State Medical Association, the Atlanta Society of Medicine, etc., etc.

Since I received my first twenty grains of the hydrochlorate of cocaine (a part of the first two-drachm package that arrived in New York), I have used many ounces; perhaps, altogether, by myself and assistants, nearly as many pounds as myoriginal package contained grains.

It will not be amiss for me to say in the beginning, that I now have very different opinions of its uses from those I entertained during the first years of its advent. However, one of my original opinions of its applicability has only become more and more confirmed with my increased use of it: and that is that its utility is principally confined to its local application to mucous membranes.

*Read at the tenth annual meeting of the American Rhinological Association, at Indianapolis, September 22, 1892.

The softer the mucous tissue to which it is applied, the sooner is its effect reached and the less the quantity necessary; and, as a consequence, the quicker and more decided is the toxic effect when its application is persisted in to this extent.

The general symptoms, however, are, everything else being equal, much oftener present in proportion to the area of membrane surface involved, than in proportion to the strength of the solution applied. Hence, sprays of a weak solution are liable to produce toxic symptoms, when much stronger solutions can be applied with a saturated cotton probe or wad, to a limited area, almost with impunity.

The constitutional effects of cocaine are manifested by a feeling of faintness—it may be even to the loss of consciousness—a trembling of the limbs, a pallor of the face, etc., any or all of which may appear in one minute or in fifteen minutes after the application to a large surface. Again, these symptoms may be produced by a small quantity of a one per cent. solution in one individual and not in another, even if in the latter both the strength and quantity be ten times multiplied. I have never yet reached a conclusion as to the average amount of cocaine that is necessary to produce the constitutional symptoms, neither do I ever know, the first time I use it, how to estimate the individual's susceptibilities.

Every individual seems to be a law unto himself as to the quantity necessary in his own case to accomplish complete local anæsthesia, and even in the same person the amount will vary at different times with no apparent cause. Under similar circumstances I find it impossible to reach a complete local anæsthesia in some, short of the toxic symptoms; when in others, one-tenth of the amount and one-tenth of the time will render the application of a galvano-cautery absolutely painless.

To obviate the unpleasantness and delay caused by the constitutional symptoms it is my custom to administer a stimulant of brandy or whisky at their first indications, and make the operation quickly and, always under such circumstances, painlessly. When it is found by trial that one bears

the drug badly, it would be well always to give a stimulant before the second application is made.

I am sure that the last thousand galvano-cautery operations I have made would represent a much greater per cent. that were absolutely painless than the nearly three thousand cauteries that preceded. Perhaps this has been due to my greater familiarity with the technique of cocaine applications in the more recent cases.

In some its effects in the superior pharynx are peculiarly distressing, more especially at the first application, but less and less so afterwards. However, it is well to remember this and avoid it, when making local applications above, by not allowing the solution to gravitate from the cotton plug.

The time necessary for cocainizing a mucous membrane is perhaps as indefinite as the strength of the solution, both due to that unknown quantity, the individual. Approximately, however, four to ten minutes and a four to a ten per cent. solution for a small surface may be regarded as an average. If the intention is to produce the effect over a small surface only, as in galvano-cautery operations, a concentrated solution—ten to twenty per cent—should be used and the result expected in four to eight minutes.

If, however, a general turgescence of any membrane should suggest the use of cocaine, a spray of a very weak solution—a one or a two per cent—should be expected to accomplish the desired result in one or two minutes. In either case, the general effects may appear without any warning and mar the anticipated good results, or at least, render an otherwise easy operation, tedious and unpleasant.

It has been my custom from the beginning to make my solutions at the moment I use them and to vary their strength according to the case, and as I use no weights or measures I never know, only approximately, the strength. The range is so great that I hesitate in stating it as I have not space to give my reasons for sometimes using a one grain to the minim solution, and again, only a one grain to five hundred minims. As a general rule, however, the strength should be in inverse proportion to the surface to which it is applied. Since my many disappointments with ready-made solutions of cocaine,

during the first few months of its advent I have never risked any solution that had not been recently dissolved.

In case it should be necessary to dissolve a large amount, it would be well to add boric acid for its preservation, in a proportion of about one grain of the latter to ten grains of the former.

For safety, it is best to supply the drug instead of giving the patient a prescription to have filled and bring with him for an appointed operation. The operation will thus be less magnified in the patient's mind, and he will be less liable to familiarize himself with the proportions and uses of the drug, should the temptation to use it himself arise afterwards. For these reasons, I do not, in any instance, give a patient a prescription containing cocaine as its leading ingredient.

As an ingredient in sprays, I find it abused more, perhaps, in hay fever prescriptions than anywhere else. This is true also where it is prescribed in the form of powders for this disease.

The turgescent condition of all the mucous membranes of the upper respiratory tract, especially in the nasal turbinates, that is always present in hay fever patients, is so quickly palliated and rendered bearable, that the temptation is great to prescribe cocaine in some form for the patient's own use; but it is a dangerous experiment, and one to be ventured upon only in exceptional cases.

During the past few years I have seen many journal articles that claimed for it a decided aphrodisiac effect, while my observations have been universally to the contrary. It will not be departing too far from the subject if I mention the effects of cocaine (through the mucous membranes) upon two cases of priapism, notwithstanding the fact that the results in these cases were reached through the general systemic impressions of the drug. The two young men, who were the victims of this rather unusual disorder, came under my observation by accident, and at intervals of about three years; each came to my office in a carriage for a coincident nasal and pharyngeal inflammation. Cocaine dissolved in vaseline, together with a small quantity of campho-mentholine, was

sprayed into the nasal and pharyngeal cavities, to the great relief of all the unpleasant symptoms in these regions.

But this was not all. In the first case, to my surprise and to the patient's great joy, the other and more painful malady disappeared within ten minutes. In the second case, the symptoms were almost exactly like the first, and the patient's delight was greater than my surprise, as I was this time anticipating a similar result from the same treatment. The relief of the priapism in both cases remained permanent.

In both instances, the usual treatment for such cases had been resorted to apparently without any result for twenty-four and thirty-six hours respectively, only to be completely relieved by a cocaine spray used upon a distant mucous membrane for a coincident malady. It would seem that in these cases cocaine acted as an anaphrodisiac, and it should not be surprising when we remember that its primary effect is to reduce a turgescence of the turbinates, and that these tissues are analogous in many respects to the erectile tissues that are involved in priapism.

I desire here to emphasize most decidedly one contra-indication in the use of cocaine as a collyrium, and that is that *it should never be used when an abrasion of the cornea exists;* nothing in the form of a collyrium is more deceptive, as it is also most grateful to a denuded corneal surface.

The cornea is covered with the epithelial layer of the conjunctival mucous membrane only; here no middle layer proper exists whence it can derive its nutrition, hence it quickly loses its vitality when subjected to this local anæsthetic. So also, the outer layer of the cornea, receiving its nutrition by imbibition only, seems to be even more susceptible to the destructive effects of cocaine.

I have seen a number of cases, during the last few years, (especially since this drug has been introduced into general use), in which the cornea has been greatly damaged by its constant and frequent introduction, for no other purpose than the temporary relief of pain; but unfortunately the relief thus produced proves to be a delusion, and the destruction produced upon the cornea is only masked for the time by the anæsthetic effects.

I have especially seen these bad results in the cases of physicians who had themselves persisted in its use for the comforting effects to their own eyes, both during the presence of foreign bodies on the cornea and after their removal.

Cocaine is contra-indicated also in any corneal inflammation, and should not be prescribed beyond the acute stage of any form of conjunctivitis.

I have had but little experience in its use beyond its local application to mucous membrane surfaces, because I have never believed that its range of utility extended any further, except perhaps, in a very few instances; hence I know very little of its general usefulness hypodermically, as it has usually seemed to me to be quite as painful to introduce it in this manner as the pain of a minor operation would be, especially when we consider the limited quantity that can be borne when it is introduced so directly into the circulation. I have sometimes, however, injected the solution into the tonsilar mass to to hasten anæsthesia, but the toxic effects follow so quickly after its introduction into the circulation in this manner, that I always hesitate to resort to this means in an untried subject. Yet, in some operations on the eye, as in tenotomies, iridectomies, cataract operations, etc., I frequently use the syringe for introducing a weak solution—one to two per cent.—subconjunctivally, in subjects that do not succumb to a four to six per cent. solution applied superficially for fifteen to twenty minutes at short intervals.

In preparing for a tonsil amputation, I use a cotton probe saturated in a five to a fifteen per cent. solution, and apply it to the whole surface of the mass once; then I send the patient to a waiting room and perhaps in the meantime—about eight or ten minutes—see another patient, then make a second thorough application, and wait three to five minutes before I use my knife and hook tonsilotome.

Occasionally, in an extremely sensitive patient who has not by this time exhibited any of the general effects, a five per cent. solution may be introduced into the tonsilar mass with a long hypodermic needle before proceeding to amputate.

In nearly five thousand tonsil amputations (four-fifths which were done under cocaine) I have never had a danger-

ous hemorrhage, and not more than a dozen cases that even proved to be troublesome from this cause.

Undoubtedly, cocaine exerts a decided hæmostatic effect upon hypertrophic tissue, especially when it has thoroughly saturated the mass before an incision is made. Yet, after the solution of continuity, its blood-staying qualities are not equal to many other hæmostatics, and it cannot be relied upon for this purpose.

During the first years of its use, this drug was vaunted by many writers in the medical journals as a great panacea—as *the sovereign remedy* for ear-ache, but, naturally, disappointment followed quickly in the practice of these theorists, who seemed not to remember that the outer layer of the membrana tympani was not a mucous layer, else they failed to remember the fact that an aqueous solution of cocaine could be only sparingly absorbed through a cutaneous epithelium.

After the rupture or incision of the drum membrane in an acute catarrhal inflammation of the middle ear, when it becomes possible for the solution to reach the membrane involved, the call for relief from pain has already ceased. When it is practical to introduce a few drops of a strong solution into the middle ear cavity through the eustachian tube, the pain is usually relieved at once; but as it is not always possible to do this on account of the swollen mouth of the tube, and as another question arises here beyond the scope of this paper, as to the advisability of the trial in any case, cocaine cannot be regarded as so great a panacea in ear-ache as it was first claimed to be by many who wrote only upon faulty theoretical grounds.

I have occasionally heard of cocaine habitues, all of whom were physicians, but I have had no personal experience with these unfortunates. Such cases will be found to be linked with the whisky habit in the great majority of instances.

I think, however, that we should always remember the danger of such a consequence when making a prescription containing cocaine, and be guarded when even its suggestion arises.

Like all drugs that are potent for good, cocaine is also potent for evil. Like fire, it is a good servant but a bad master.

A CASE OF CHOREA, ASSOCIATED WITH MITRAL INSUFFICIENCY, SUCCESSFULLY TREATED WITH DIGITALIS—WITH REMARKS ON CHOREA.

BY JEFF S. DAVIS, M. D., MONTEVALLO, ALA.

In April, 1891, Miss M. R. applied to me for treatment for chorea of eight months duration. She had been treated by several physicians, and all the remedies usually administered in this disease had been tried. Among other drugs she had taken Fowler's solution in heroic quantities, having had administered by one physician thirty drops hypodermically, three times daily, for several days.

Antipyrin, the bromides, spinal sprays and electricity had signally failed to relieve or to noticeably mitigate the exhaustive, incessant, clonic spasms, which as she expressed it, were gradually "shaking her life away." The following history of the case, copied from my case book, was furnished by her mother, who was of marked nervous temperament:

Age 19; father died of phthisis pulmonalis, age 51; patient very anæmic since one year of age; had a protracted case of typhoid fever when ten years old, which was followed by a cough of eighteen months duration; menstruated at fifteen, but was never regular, a period of from three to four months usually intervening the catamenial epochs, which were always menorrhagic in character; had suffered repeated attacks of acute articular rheumatism during the preceding two years—the last nine months prior to the time that she came under my care; had been coughing several weeks and expectorating sputa tinged with blood. Immediately after the subsidence of the last attack of rheumatism the first choreic symptoms were noticed. The facial muscles were first affected, and very soon afterwards those of the neck and extremities of both sides. The contractions, which were at first slight, gradually became more pronounced until locomotion was impossible. On examination I found anasarca of lower limbs, dyspnœa, pain in precordial region, constipation,

tongue large and pale, pressure 140 and very weak, respiration hurried. Physical examination revealed bilateral mucous rales and a mitral systolic murmur. The murmur was unusually loud and propagated towards the left axilla, and quite audible in the left vertebral groove. Mitral insufficiency was painly evident, and having determined the cardiac lesion, the anasarca, bronchitis and dyspnœa were recognized at once as patent symptoms of that affection. The chorea, however, could not be so readily assigned a course, and the whole category of recognized remedies having been exhausted without materially effecting its course, the prognosis was naturally unfavorable. Realizing the importance of a plan of treatment essentially different from any adapted by my predecessors, I studied particularly the etiological aspect of the case for any knowledge that would suggest a definite line of treatment. The conclusion finally arrived at was, that malnutrition of long standing intensified by the valvular trouble were the principal etiological factors in the case. The following was accordingly directed:

R. Tr. digitalis,.....oz. ii
Tr. ferri chlor.,.....oz. i
Glycerine,.....oz. iii
M. Sig. One teaspoonful. t. i. d.

The efficacy of this combination can be seen at once. The digitalis restoring the relation between arteries and veins through its specific action on the heart, thereby increasing the quantity of oxygen and blood distributed to the various tissues, while the iron, by building up the histological elements of the blood, tends to obviate the results arising from a diminished quantity due to the cardiac lesion. A highly nutritive, easily digested diet was directed. Ordered her to take food in sufficient quantities to appease appetite, and in addition to this to take each day three soft boiled eggs and one pint of fresh cream, as blood material. The two latter were to be taken over and above the quantity called for by her appetite. For the constipation and to promote digestion, prescribed:

R. F. E. cascara sag.,.....dr. iv
Elix. lactopep.,.....oz. vii ss
M. Sig. Tablespoonful after meals.

For insomnia, she was given sulfonal, gr. xviii, at bedtime. The glandular system received scrupulous attention, small doses of calomel being frequently given when indicated.

A detailed account of the daily progress of the case is not necessary. Suffice to say, that the fifth day after beginning the treatment there was marked improvement. Dyspepsia very slight, cough less frequent and sputa only sparingly stained; pulse 98 with good volume; anasarca disappearing and a decided abatement in the involuntary muscular contractions. With the exception of discontinuing the sulfonal, no change was made in the treatment at this time. Improvement was uninterrupted, and by the twentieth day there was no symptom of chorea, no bronchitis, no anasarca. A great change had been effected in her appearance in this short time.

The eye, which had regained a degree of its wonted brilliancy; the wan cheek delicately tinted by the rosy hue of health, together with the increased color in the pallid lips, bore evidence that nutrition was much improved. As the kidneys were functionally active, I apprehended no danger from the reputed accumulative effect of the digitalis, and when my visits were discontinued, after the thirtieth day, she was directed to continue the treatment and requested to report at my office every two weeks. As too often happens in such cases, where directions are not enforced by rigid supervision, she was soon lulled into a state of indifference by the erroneous idea that she was cured, and all treatment abandoned. With a mitral lesion in a non-compensating heart, the result of withdrawing the digitalis may be easily imagined. Re-establishment of the previous symptoms rapidly ensued, and the chorea was, if possible, more severe than when I first saw her. The same course of treatment detailed above was directed, and while the case did not yield so readily to treatment as in the first instance, her condition was in two months as favorable as before the relapse.

Having profited by this experience, she realized the importance of continued treatment, and no further trouble was experienced in having her follow directions.

When the defecatory functions were normally established,

the cascara sagrada was discontinued, and cod-liver oil given before meals with elixir lactopep., dr. iv, immediately after meals. Before coming under my care she had been treated for rheumatism, and there has been no symptom of that disease for more than a year. She has taken the digitalis and iron mixture and lactopeptine almost continuously since I first saw her. Cod-liver oil is given until it begins to nauseate, when it is left off, and the hypophosphites given for two or three weeks.

Her condition is at present almost incredulously good, and notwithstanding the fact that she has a grave cardiac affection, is able to engage temperately in the various pleasures of life. The chorea is apparently permanently cured, though in my opinion a relaxation in treatment would be speedily followed by its return.

REMARKS—The history of chorea dates back to the middle ages, and from that time to the present day many theories have been formulated to explain its cause, and many methods advocated for its abolition. To transcribe the various conditions considered as having an etiological relation to chorea is unnecessary, as the literature on the subject is voluminous and accessible to the student. Pathologically considered, the disease is apparently on the border line between the functional and the organic; post mortem investigations revealing in some cases anotomical characters, while in other cases no such characters are discoverable.

"Dr. Dickson, in a large series of examinations, found dilatation of minute arteries existing throughout the brain and cord, more especially in the corpus striatum and thalamus with small hemorrhage, and believed the disease to be due to a widespread hyperæmia of the nerve centres." (Broadbent).

The embolic theory of King and Jackson is familiar to all, while rheumatism and its sequels are so intimately associated with chorea that more able investigators have considered the disease essentially rheumatic.

From the fact that in "almost all fatal cases of chorea there exists endocarditis with deposits of beads of lymph on the mitral or aortic valves," the cardiac and embolic connec-

tion and its relation with rheumatism is readily appreciable. Yet there are other cases preceding or co-existing with an attack of rheumatism where there is no evidence of endocarditis, which are obviously due to causes other than the lodgment in a cerebral vessel of fibrinous shreds from an inflamed endocardium. In many cases nothing abnormal has been detected after death. Pregnancy, intestinal worms, onanism, and even anæmia in one predisposed, are often the only conditions present to which the disease may be attributed. It occurs more frequently in families in which nervous diseases are hereditary; and bad hygienic surroundings, together with improper food play no unimportant part in its production. Of the remedies for chorea, the preparations of arsenic are the most potent, and the majority of cases will be cured when they are properly administered. That it is not always amenable to this treatment, however, is evinced by the case reported. But the scope of this paper will not permit an elaborate discussion of the etiology and treatment of chorea, and the above remarks are only intended to remind the reader that no one condition or agent can be accepted as the only cause of chorea, and consequently no single line of treatment expected to prove infallible. Where possible, remedies should be administered to meet the indications in each individual case, in this disease as in all others. The fact that the "irregular clonic muscular spasms" is a morbid manifestation or symptom, and not a disease, *per se*, should be kept constantly in mind.

A desire to call attention to the benefit derived from digitalis in the treatment of chorea associated with valvular lesions, is the motive which prompted the report of the above case. That such cases are of rare occurrence, I admit, but when the conditions attending mitral insufficiency are taken into consideration, its importance as an etiological factor in chorea is at once apparent. That anæmia is a recognized accompaniment of chorea, and in some cases the only discoverable cause, all will admit, and it is reasonable to suppose that mitral insufficiency, or rather the anæmia resulting from the diminution of oxygenated blood in the tissues, may in itself or by intensifying pre-existing anæmia, deter-

mine an attack of chorea in one predisposed. In such cases, every effort should be made to improve *nutrition*, and in addition to other treatment, digitalis by restoring the relation between arteries and veins, will prove very advantageous. It will effect cures when all else has failed. It should be given in *every* case of chorea associated with a heart lesion for which the drug would be ordinarily prescribed, and in these cases it i sas distinctively curative in its effects as Fowler's solution.

THE RADICAL CURE OF HERNIA, PARTICULARLY WITH CHILDREN.

BY DR. G. FELIZET, SURGEON TO TENON HOSPITAL, PARIS, FRANCE.

Translated by THOS. H. MANLEY, A. M., M. D., Visiting Surgeon to Harlem Hospital, New York.

(*Continued.*)

We will often find the trouble attributable to the testis, when this organ has not descended into the scrotum. It is often possible, if the cord is supple and the testis has not contracted adhesions at the opening of the canal, to lower it and permit the intestine to pass. Sometimes force, gently applied, will bring the testis well down. It is here where we find suturing the ring useful. But the situation is sometimes very embarrassing, and many surgeons have not hesitated to castrate, under these circumstances. The intestine reduced, little remains to be done, but to complete the operation with ordinary precautions.

(*d*) The hernia is totally irreducible.

Herniæ totally irreducible by adhesions are not observed in children. It is in the adult, following repeated engorgements and pressure on hernial peritoneum, that we see established this unfortunate condition of things. The herniæ presented are not generally the "strangulated variety," but they are "accidental" herniæ, painful and troublesome, for which the operation for the radical cure is necessary, sooner or later.

For this order of cases, the employment of our apparel,

the balloon, is useless and the dissection is long, difficult and perilous. It is because of the unequal and uncertain volume of the epiploon or intestine, the surgeon having no guide to the serous membrane of the sac. The enterprise is all the more difficult because of the thickening and change in consistence of this membrane by exudates and adhesions anteriorly.

Nothing is easier than to become bewildered in the incertitude of a dissection so obscure, or liable to bruise or wound the intestine. It is an affair requiring tact, patience, circumspection and the keen employment of sight, smell and touch. It requires a long time to complete the operation, many times an hour or more. But, as we have said, this type of adhesion is not encountered often in children, and is still less in infants; that is, in those who badly sustain surgical intervention of long duration.

THE RADICAL CURE AFTER KELOTOMY.

A patient is overtaken by the dangers of a strangulated hernia. Taxis not succeeding, we practice a kelotomy. The intestine is returned. The patient is cured; that is to say, his life is saved and he has survived his perilous experience. Sooner or later, the intestine again occupies the sac; the return of the hernia is almost inevitable, if we do nothing further than release the constriction.

The reproduction of the infirmity, eventually with all its former troubles, has in all times, pre-occupied the thoughts of herniotomists, and the list is long of the means imagined and tried, which would establish a definite cure after reduction of the protrusion.

We find in the classic treatise of En. Paul Legoud, a description most complete of many of the methods and apparatuses which have been conceived, invented and tried, to assure the radical cure of a hernial infirmity. We see, that in early times, the number of preventatives equal nearly the the number of appliances, yet at that time, the mortality was very high. Before the days of antiseptics in surgery, the length of time consumed in operation, the uncertainty of its results, the frequency of suppuration, the propagation of inflammation towards the peritoneum, the danger of killing the

patient by operative manœuvre itself, the efficaciousness of which, at best, was more or less problematical; all seemed, during the past century and a half, or longer, to have rendered surgeons circumspect; so that even to-day, the masters who undertake the radical cure after kelotomy, are not infrequently ridiculed.

The actual tendencies at present, are greatly changed. Surgery of herniæs has become practically harmless in its boldness and our manœuvres; for radical cure do not add to the difficulties, the dangers which an elder generation of operators feared.

The operation for radical cure is not in truth, however, to be regarded as an audacious and reckless interference, or an enterprise of rashness and insurmountable difficulties.

It is wrong to pretend to perform a great operation for a condition which is not beyond the reach of every surgeon to succeed with. We may rest assured, as we have said, that it is an operation simple of execution; as mediocre qualities only are called for. Patience and good judgment are common pre-requisites, which represent, we might say, the authography of surgery. When we attentively observe the progress of those radical cures properly conducted, we are astonished with the advantageous statistics. With all eventualities anticipated, and ample care exercised, the death-rate will become almost *nil.* The difficult question is not, to not kill your patient, but to cure him of this infirmity. Now, we may completely cure a hernia when we deal properly with the neck and sac, but the result is not realized unless operated as high as possible.

In the operation, in the beginning, for radical cure, made the occasion of a kelotomy, the ablation of the sac is laborions, and it is to one's advantage to free the constriction, when we may easily extirpate an anatomically normal pedicle; but when we are in the presence of a membrane, red and inflamed by recent injury in attempts at reduction, adherent at the sides and underneath, and where the dissection is attended with free hemorrhage, we have a difficult, complicated case. There is considerable blood spilt and much time lost—the points on which we will later dwell—because they constitute

two factors most principal in the way of success of operation in early infancy. We may add that the integrity of the neck is always altered after kelotomy; may be it has formed an unique bridle. One may sometimes in dealing with it, follow the counsel of Louis and Vidal (de Cassis), and practice small, radiated sections; and then we separate the serous membrane, tediously dissecting in escaping blood; raise the parts in fragments to be lost and then found; search for the neck, so that now we have more or less laceration of the sac, that part so necessary to have intact, to give solidity and guarantee of cure of perfect and permanent occlusion.

The procedure by distension with the balloon, not only clears up the obscurities in dissection, but permits us, also, to have immediately under the eye the sac and neck, which we ligate with cat-gut, and divide. It also permits of a neat, rapid and bloodless operation. It possesses advantages of greater value than any other since operations were originally devised for radical cure of hernia in children. To demonstrate this, we report the following case in an infant twelve months old, afflicted with a strangulated hernia.

Stangulated inguinal hernia; twelve months old; repeated taxis failed; kelotomy and radical cure—recovery.

Charles N., brought to Tenon Hospital, June 25, 1890. The father was a tailor, was the subject of an inguinal hernia since infancy; but he was the only one in his family so afflicted. Our little patient was healthy and vigorous, born at term the preceding year. He had never been ill. Never had whooping-cough nor measles. Digestive organs active. He had been nursed in the country during his first nine months. His testes were well descended, and his naval scar was well cicatrized. When 6 weeks old, it was noticed that he had a hernia. He was brought to Paris and a truss was adjusted; he was returned to his mother when three months old, his infirmity continuing.

Many different trusses were applied, but none could completely control the hernia. They all caused incessant pain, and it came down with great facility. The mother said when the hernia was returned, a distinct gurgling sound was audible. On June 24th, the hernia came down in great volume,

and was much more indurated than usual. He cried constantly. The mother tried vainly to return it. A physician was called in, and resorted to various expedients; but they all failed. The Wednesday following, at 6 P. M., an *interne* at the Hotel Dieu, tried taxis for fifteen minutes, but failed. We then telephoned to the hospital to prepare a bed for him.

More than two hours then had been occupied with tentative taxis. He cried constantly, and the crying visibly augmented the volume and tension of the hernia. The abdomen was tympanitic and hard. He had two spells of vomiting after he entered the Hotel Dieu. His features were not pinched and his general condition was not bad. The pulse was full and regular.

The renal functions were normal, and he passed a large quantity of urine before we operated. The hernia was of the size of a small pear (three times the volume of an infant's thumb), being smooth, regular and painful everywhere. We could not find the testicle. On the left side, the testis was felt of normal volume and correctly placed. No ecchymosis nor œdema in the scrotum. In an adult, we would be justified, in a case presenting the phenomena present in this case, of predicting a favorable result. But here, we had a congenital hernia, actively inflamed; its neck straight and tightly gripping the intestine, while the danger was augmented by length of time it was down, and the protracted efforts at taxis.

It was now important to proceed without loss of time, while the child was in good condition, and try kelotomy if we would accomplish any benefit. In this state, while everything was being gotten in readiness, the lavage prepared, the instruments arranged and the patient anæsthetized, moderate taxis and iced applications were tried. After five minutes trial, it was decided to proceed with the operation. Operation at 6 P. M., June 25th, assisted by my *internes*, M. M. Camascesse and Pescher; commenced by making an incision five or six centimetres in length, from the ring downward. But one ligature was necessary to secure an arteriole in the external lip of the incision.

We proceeded rapidly, and with two or three cuts of the scalpel, the sac was nearly exposed. It was seized and

Plate IV

opened with every precaution, and there escaped a half teaspoonful of coffee-colored serum. It was nearly a dry hernia. The opening was now enlarged with the scissors, and maintained with two forceps. We now saw that the serosa of the intestine had been nicked by the scissors, but it was so small it did not prevent direct reduction of the intestine. The finger was now introduced and carried to the base of the sac, where the testicle was recognized in its normal position. Taxis direct now applied, made no impression on the hernia; hence, Cooper's hernia bistoury was introduced before and posteriorly, and a section made of a firm hard body at the neck of the sac, well accentuated. Reduction was now made without difficulty; careful lavage of the sac and testis.

The intestine returned, the internal surface of the sac was wrinkled in longitudinal folds, velvety, and of a rosy hue; in fact, it bore a striking resemblance to the empty bladder. It is certain, that under ordinary management, the peritoneo-vaginal pedicle would give rise to free hemorrhage or division, while with the balloon, none was lost. The balloon being engaged in place of the withdrawn finger, its small extremity is carried up as far as possible in the inguinal tract; the wall closed, we insufflate gradually, so that a genuine ovoid tumor is formed. Now the separation of the elements of the cord is easy before we allow the artificial pouch to collapse. The separation of the neck of the sac was effected as high as possible, in such a manner as to avoid injury by the bistoury. Moderate tortion was then made followed by traction in a downward direction. It was ligatured by cat-gut. Section was made one centimetre below; the ligature disappeared instantly into the abdomen. The sac was reversed and excised. Sufficient of it was preserved below to vaginalize the testis. The hernial sac was homogeneous, thin and transparent.

It had the capacity of an egg and weighed twenty-eight centigrammes. Irrigation with boracic acid solution; suture with catgut; drain. Dry dressing with powdered salol; kelotomy, reconstitution of the sac; technique by radical cure, suture; all accomplished within twenty-five minutes.

Ten grammes of chloroform used. He lost ten grammes of blood. The subsequent dressings were exceedingly simple.

June 25: During the day no pain, no vomiting. Abdomen still hard, urinates freely. He is playful, drinks grog and milk, rectal temperature 38 degs. C., no gas nor evacuation.

June 27: Emits gas this morning. Abundant motion. We removed the dressings, fearing that they might be soiled by urine or fæces. There was nothing. The sutures hold well. The region is red and tumified; no pain; to be returned. Dry dressing with salol.

June 28: General state excellent; motion normal; temperature 38 degs. Truss removed. The youngster sitting up. Nothing more to note after this.

July 10: Left the hospital.

We last saw him July 29, when there was no more tumefaction, pain or re-appearance of a hernia.

RESULTS CCNSIDERABLE TIME AFTER THE OPERATION FOR THE RADICAL CURE OF HERNIA.

We have for a long time, a procedure which makes the operation for the radical cure of hernia, when practiced on simple or strangulated, an operation simple, easy and inoffensive, and we have explained a method which has a surgical advantage in giving precision and rapidity; besides economical in the loss of blood, which does not generally obtain, and which assures us the dissection of the peritoneal investment without extensive mutilation of the fibro-muscular tissue. It guarantees occlusion of the canal, strengthening of the track and suppression of the feeble point.

With minute precaution, we wish to be permitted to hope to realize a radical cure and definite result; "a hernia which exists no more and cannot return." Will we be disappointed in our hopes? We had twenty cases without a death, of which sixteen returned after a variable time, from fourteen months to three years. We have had two re-appearances complete in the scrotum; two re-appearances of hernia, not passing the groin; four incipient returns, and eight definite cures.

The eight relapses were of different degrees, with the sixteen cases which returned for examination. This figure, 50-100, represents the exact facts. It would scarcely express the full truth, however, because in sixteen cases the anatomico-pathological conditions were very dissimilar, as our clinical observation of them differed, and they had multiple features, although in their gross character were similar.

Age dominates prognosis, when the question of radical cure is considered. The results are more certain with the young adult than the old man, for with the latter the hernial track is capable of but little modification. Possibly the gap may fill in by an adventurous formation sufficient to sustain the pressure of the viscera, by the aid of the bandage, when a patient's condition is such as demands something to be done, as a temporary or tentative measure. The ring may be narrowed, which will all the more accentuate relief for a condition destined to be aggravated progressively in time. In those latter cases we may hope for much benefit from operation, as we can promise nothing.

It is otherwise in childhood. At this age, the young tissues, stretched by the passage of the intestines, offer us all the advantages of their suppleness. The pressure which distends them, at one time, often ultimately tends to efficiently restore the former normal position. The fibrous tissue in youth is wanting in that definate rigidity, neither that which is specially vitalized, nor the fasciæ or aponeurosis.

Finally, the irritation provoked in the operative region is active and rich in proliferation. This is not all; as one must, in appreciating the results of hernial operation during childhood and early life, take into account the absolute fact of the *natura naturans* of reparative vitality, he must also look to relative changes, occurring with age in this region proportionally as age advances.

Inguinal hernia is located in a triangle which has for its sides the arcade of Fallopius below; a part of the inferior extremity of the linea-alba, internally; externally, a horizontal line extending from the center of superior spine of the ilium to the linea-alba.

The longitudinal course of this triangle, in an adult of ordinary height, for example, being 100 centimeters and the face of the orifice being five centimeters long, one would say that the relation of the hernial opening at this part of the abdominal wall, is from 2, 5 p. 100. We can easily perceive, then, that in an adult operated on, the track being free from the assaults of a pressing hernia, the external orifice retracting the least, the relations would then be more than or thereabouts, 2, 5 p. 100.

With the child, and I do not wish to speak of the newborn, but with a child of six years, for example, I suppose that the face of the fictitious triangle would be thirty centimeters wide; the relation between the hernial opening and this part of the abdominal wall, would be more than with an adult, say from 6, 5 p. 100.

If the hernia, having been operated on and its orifice only retracting, the ratio after cure would be 3, 25 p. 100; but it must be admitted that the space in the triangle would not increase in the physiological development of the young subject. Now, we know that between the sixteenth and eighteenth year, the limits of the triangle more than double; and if we admit (and we are rather under estimating) that the external orifice may be diminished, as with the adult, we would have an opening one centimeter wide, on a triangle of seventy centimeters in its greatest length; that is to say, a relation from 1, 4 p. 100, instead of 3, 25 p. 100 with the surface of the triangle as we have indicated.

The child grows, and each year progressively diminishes, proportionally, the track, until its conformation and dimensions are normal. This is not all; for while the rent in the triangle is weak, it retracts by its relation to the surface of the abdominal wall the calibre of the intestine at its side in such a manner that one part of the track is most straight, and the other viscera having augmented in volume, the conditions which produce the hernia have become obliterated.

The result of a successful operation constitutes an obstacle. The natural development has been transformed, rendering a relapse an impossibility. To effect this impossibility, is the ideal objective in the radical cure of hernia, and indeed, it

often does become a reality; thanks to the organization of a perfect obstacle, to the tissue of the intestine. We have long explained this as the perfection of operation, which leads to the permanent effacement of the peritoneal funnel and the constitution of a solid support. Now, it is by the insufficiency of this support that we have relapses.

(*To be continued.*)

OBSTETRICS AND GYNECOLOGY.

BY E. S. M'KEE, M. D., CINCINNATI.

At the meeting of the Obstetrical Society May 19th, Dr. Rufus B. Hall reported a case of pyosalpinx with abscess of the ovaries, and showed specimens. The patient, aged 31 years, widow, with one child 6 years old, was referred to him by Dr. Max Koehler, of this city. The patient had complained of some pelvic pain for more than a year, yet it had not been so severe as to totally disable her from her work of dressmaking. When she applied to the physician a short time before, he recognized the tumor in the pelvis, and advised an operation, after a consultation, the speaker agreeing with him. She did not consent to the operation for about two months, continuing to go several blocks twice daily from her boarding house to her work. She grew gradually worse and the pain became more severe, so she finally agreed to the operation, which was made April 21st, and the specimens here presented removed. The left tube is as large as the index finger, and contains pus; while the ovary was enlarged to the size of a pint cup—a mere shell filled with pus. They were universally adherent, as will be observed. Just as the ligature was being placed, the patient vomited, the sac ruptured, and the greater portion of the pus was turned out, and some of it spilled in the pelvis, which was thoroughly washed out. Enough pus remains so that the specimen is as large as a tea cup. The right tube was as large as the left, and also contains pus, while the ovary is the size of an orange with pus in it, as will be observed when it is laid open before you. An

interesting feature of the case is that the patient could walk and work and apparently suffer so little pain with this large quantity of pus in her pelvis. This patient weighed 165 lbs., and had the appearance of perfect health. Her case is reported to emphasize a point on which the profession is not agreed, but without which I am convinced this case would have been lost, and after which she made a rapid and complete recovery. I refer to re-opening the abdomen. After the operation everything went well for a few days. The drainage tube was removed 48 hours after the operation; the pulse ranged from 70 to 80, with a temperature from 98.8 to 99.4 until the morning of the 5th day, when the temperature was 101; yet the patient did not complain. The temperature was 101.5 in the evening, with some discomfort in left side of pelvis. The symptoms grew worse from this until the morning of the 8th day, when in spite of large and repeated doses of phenacetine her temperature was 103.6. The abdomen was re-opened and fully a pint of pus evacuated. The cavity was washed out and drained. In three hours the temperature was 100, and but once after that time did it reach that point. She made a rapid recovery. I have reason to consider it a surgeon's duty to re-open the abdomen after pus cases when similar symptoms to the case reported are presented. It is a procedure I can recommend most heartily from personal experience, and in my judgment it is not so dangerous as generally believed.

Dr. Gustav Zinke reported a case of dystocia from dislocation of the cervix during labor. The doctor reported the case not to teach the society anything, but to ask if any members of the society had met with a similar case. The patient had suffered intensely from dysmenorrhœa, but was healthy otherwise. The patient suffered from insomnia for a week before the delivery, and was given chloral, bromide of potassium and codeine, without much benefit. She suffered from pain in the back without intermission. Two days before labor set in in earnest the pains became intermittent in character. External examination led to the belief that the position was the third position of the vertex. As the pains increased, the patient became more and more restless and labor still did not come on.

Later, the pains became more regular, the patient bearing down as much as she could. On digital examination the os was found so high up that it was impossible to get the finger into it. It was pointing directly against the sacrum, and the lower segment of the uterus, very much thinned, presenting. The doctor tried to introduce two fingers, get one into os and drag it down. Although very careful to avoid rupturing the membranes, the liquor annii escaped about this time, but he could not believe it was his fault. This complicated matters and was to be regretted. Chloroform anesthesia was induced and the smallest sized Barnes dilator introduced. This remained *in situ* till six o'clock. There was no obstuction to the child's head except the undilated os. Dr. Eichberg was called in consultation. He gave chloroform, and delivery was effected with the aid of the forceps. The patient has a severe pain which has been present every since confinement. There is no odor or other bad symptoms. The highest temperature reached was 103. He believed the cause of the dislocation of the os was the contraction of the sacro-uterine ligaments. He had two cases before, which were somewhat similar to this and very slow in delivery. The patient was placed in the knee-chest posture and kept there as long as she could stand it; but this failed to correct the dislocation.

Dr. C. D. Palmer thought the condition in Dr. Zinke's case was due to a congenital elongated cervix, the so-called conoid cervix.

Dr. A. J. Miles has been successful in changing the position of the cervix, by changing the position of the patient to standing knee-chest and so forth.

Dr. A. W. Johnstone had one case where the anterior wall of the uterus presented. He thought it possible there was some trouble at the sacro-iliac junction, which, when present, is very painful.

Dr. C. A. L. Reed thought he had had similar cases to that under discussion. He could not bring himself to believe that the trouble was due to contraction of the sacro-uterine ligaments. The doctor described the action of the ligaments to be opposite in effect to that ascribed to them.

Dr. Geo. E. Jones had a case which tallied very closely to

that of Dr. Zinke. He tried four days to get the os to dilate, and finally had to use forceps. He thought in the case reported that if the doctor had waited some time he would have saved himself trouble.

Dr. Zinke in closing said he did not think it a case of conical cervix, as it had all the appearances of a normal cervix, except that it had not disappeared sufficiently. To bring about a retroflexion or an anteflexion, the contraction of the ligaments must have existed for sometime. The Barnes dilators were not inserted till the membranes had ruptured.

Habitual abortion, use of asafœtida. (*Turazzo, Centrallblatt fur Gynekologie*). Good results are reported by this author from asafœtida in habitual abortion, when not dependent upon syphilis, tuberculosis or diseases of the womb or its annexes. He prescribes: R. Gum resin, asafœtida, f. pill No. lx. S. One pill every two days, gradually reducing frequency of dose.

Hypnotics for the relief of labor pains. (*Annales de Gynekologie et Obstetrique.*) Oui hypnotized an hysterical primipara after the os was dilated and succeeded in entirely suppressing all sensation of pain from subsequent uterine contractions. He introduced the hypnotic state by pressure upon the eye-balls through the closed lids. On releasing the pressure, the woman became conscious at once and felt the pains. The hypnotic effect could not be induced before dilatation of the os; after this was accomplished, it continued throughout labor without affecting the contractions.

Vomiting of pregnancy. (*Der Frauenarzt*, March, 1892). Routh states that in seven years practice, he has always been able to arrest the vomiting of pregnancy by brushing the cervix and lower cervical canal with a mixture of equal parts of iodine, iodide of potassium, spirits of wine, and water. Vomiting usually ceases immediately after application. If vomiting should recur, the cervix should again be brushed.

Parasitic fœtus. (*Archives de Tocologie.*) Leon reports a curious case. The patient, a girl 3 years old, was the child of native Mexican parents. She exhibited some well marked portions of a fœtal face on the left gluteal region. They were the upper and lower eyelids of the left eye with eyelashes

and eyebrows, an upper lip which perfectly covered a part of a rudimentary upper jaw, furnished with three or four well developed incisor teeth, and a small buccal cavity with a rudimentary tongue and some fluid secretion. Near to the groove between the buttocks, was a row of silky hairs. In the inferior part of the cyst, the presence of fluid was detected, and on the surface of the parts were seen some mamillary projections.

Puerperal tetanus. (*Gazette des Hepitaux.*) Vinay holds there are three things to be achieved in the treatment of puerperal tetanus: 1. Local interference with the uterine lesion to cause elimination and destruction of the poison. 2. To change the composition of the blood altered by the poison. 3. To lessen the nervous irritability. Of all the different remedies, the inhalation of cloroform up to narcosis is the most valuable. Next to this comes chloral, which may be given in hourly 15 grain doses, either by mouth or per enemata, to be continued until sleep or muscular relaxation sets in. The subcutaneous injections of morphine may be a resort. A combination of chloral with chloroform seems to be the best treatment. Repeated warm baths with subsequent packing, act as sedatives, but are not to a danger of fresh irritation. General treatment should be very judicious. The patient should be removed from physical or mental excitement, temperature of room should be regulated, bowels regular, and nourishment strengthening. Patient should remain in bed a long time after convalescence has begun, to avoid fresh attacks.

AN OVERLOOKED FACTOR IN THE PRODUCTION OF CONJUNCTIVITIS.—Under this title, Dr. Julius Pohlman (*Buffalo Medical and Surgical Journal*, July, 1892) advances the idea that the effect of heat in producing conjunctivitis, is due to dryness of the atmosphere and not to its temperature. He made several experiments, and found that the disagreeable eye symptoms, caused by hot, dry atmosphere, were at once relieved by the instillation of a drop of water. He thinks this accounts for a temperature of 70 degs. F. in a room causing conjunctivitis, when a summer heat of 95 or 100 degrees has no such effect.—*Ex.*

Society Notes.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD JUNE 3, 1892.

The 268th regular meeting of the Society was called to order by the President, Dr. Robert W. Johnson.

DR. HIRAM WOODS related a case of ectropion of both upper lids from disease of the orbital roof, and exhibited the patient.

When the patient, a colored boy, first came under Dr. Woods' care he had had abscesses over the upper eye-lid of each eye, which had ruptured spontaneously, leaving fistulous openings about the middle of each lid, from which pus exuded. With a probe, small areas of denuded bone could be felt about an inch back in each orbit. The patient was put upon tonic treatment, and the sinuses healed. The lids were enormously hypertrophied and the entire edge of each lid was fastened with cicatricial tissue to the edge of the orbit. Dr. Woods operated upon one eye in October, 1891, and upon the other three weeks ago. The edge of each lid was dissected from its position and stitched for the time being to the lower lid. The skin was freely undermined and the horizontal incision was converted into a vertical one. The results were highly satisfactory.

DR. W. B. PLATT read a paper on "Rupture of the Plantaris Tendon;" relating four cases that had occurred in his practice.

DR. CHAMBERS was inclined to doubt the existence of such a thing as rupture of the plantaris tendon. From the attachment and relations it would not be likely to rupture. The pain is usually at a distance from the weakest portion of the tendon and the ecchymosis is more abundant than we would expect to find in a rupture of a tendon. Some good surgeons incline to the idea that these symptoms point to the rupture of a blood vessel. The deep veins may be in a varicose condition.

DR. GEORGE H. ROHE related four cases of puerperal insan-

ity, in which he had removed the uterine appendages, and exhibited to the Society the specimens removed.

Case I.—White woman, 33 years of age. Married at seventeen years of age. This marriage resulted in the birth of one child. In two and a half years she became widowed, and four and a half years later married a second time. In 1882, she gave birth to a second child, and immediately afterward suffered from puerperal mania, which lasted five months. She remained well three years and then again developed insanity and was admitted to the insane asylum with acute mania. When admitted to the hospital she was excited and disposed to fight. She had especial aversion to her husband. She indulged in obscene language. She showed no improvement, but a gradual failure of mental faculties. Suffered from incontinence of urine, and paid no attention to the calls of the rectum. Exhibited great excitement during menstrual period.

Physical examination after coming under Dr. Rohe's care in 1891: Unilateral laceration of cervix up to the vaginal junction and intrapelvic induration on the same side. Perineum ruptured into the rectum.

Abdominal section performed October 6th, 1891, and appendages removed. Clinical conditions present: Right ovary cystic; left ovary cystic and adherent in Douglas' cul-de-sac; thickening and congestion of broad ligament on right side.

After history: Patient recovered fairly well from operation. Had an attack of peritonitis, which yielded promptly to the usual treatment of purgation. The stitches were removed on the seventh day and the wound found perfectly united. December 10th, patient dresses and undresses herself. Seems much interested in looking at books. Appetite good; sleeps well; does not indulge in profane and obscene language as much as formerly. A week later, very much interested in plants and flowers in the wards, and waters them regularly. Appetite good, sleeps well; general behavior very much improved. Present time: Improvement continues. Has written several letters to her husband and to her children, showing decided interest in her family life.

Case II.—White woman, aged 37 years; married 13 years; mother of six children. Admitted to the asylum, May 16,

1890. Insanity developed during the period of lactation. Previous to insanity she was amiable, cheerful and industrious. Her mother had been insane and her father was very intemperate. Had been insane three days when admitted. Had a previous attack ten years before, probably in connection with the birth of a former child, but no exact history. Was subject to hallucinations. Thought nearly every man she met was her brother in disguise. Imagined that she had the power of healing by laying on of her hands. Had a decided tendency to expose her person. Menstrual period irregular. Emaciated, with haggard appearance. Appetite poor; slept poorly; nervous and restless during the day. Put upon a special diet of eggs, milk, beeftea, brandy, etc., but improvement was very slow. The approach of her menstrual periods could be predicted by the alteration in her behavior in the ward.

Physical examination: Bilateral laceration of the cervix; thickening of posterior lip; intra-pelvic inflammatory induration of the left side, sensitive to slight pressure.

Operation November 25, 1891. Left ovary was found adherent. Breaking up of the adhesions occasioned some bleeding. Tube on the left side congested and convoluted.

After history: Recovered well from the operation. Sutures were removed on the seventh day. Note, December 17th: Patient cheerful; appetite good; sitting up in her room, sewing; conversation coherent and has at present no hallucinations, no delusions; simply nervous symptoms such as are present in the majority of cases of induced menopause. At the present time is increasing in flesh and strength; complains less and less of headache and backache and converses entirely rationally. Is much interested in the work about the place, and is ready to go home at any time her husband is prepared to make the proper provision for her.

Case III.—White woman, age 39 years. Married fifteen years. Has had seven children, the last one born four months previous to her admission to the hospital in August, 1887. Before insanity, was amiable and industrious and neat about the household affairs. No insanity was ever in her family. Insanity came on suddenly after the birth of the last child. First symptom was that some one was after her trying to kill

her. She used vulgar and obscene language. Tried to kill her mother. Her language in the hospital was of the most obscene character. She would tear her clothes, break the furniture and tear the plastering from the walls. These attacks were intermittent. About six months ago she began to fall off and at the time of the operation was pale and thin.

Physical examination: Deep laceration of cervix on both sides, with eversion of the lips of the cervix and enlargement of the uterus.

Operation December 15, 1891: Uterine appendages removed; small cyst in left broad ligament; one ovary was adherent; uterus somewhat enlarged,

After history: Recovery from operation very good. From being one of the worst patients in behavior, language and general character, she became one that could be kept upon the best ward of the house. She is not well and probably never will be. She has gained in flesh; sews, goes out on the lawn, a tends the dances regularly and behaves very well. This patient and the first one will probably never be well, as both are in a condition of somewhat advanced dementia; but they have become better patients.

Case IV.—White woman, aged 28 years. Native of North Carolina and resident of Baltimore City. Admitted in 1891, suffering from mania. Mother of three children. Had an attack of insanity after the birth of the first child and another after the birth of the second child. The third attack came on 12½ months after the birth of her third and last child. The second and third attacks considerably after the births of the respective children. The first attack was a true case of puerperal insanity and probably determined the others. When admitted, was in a state of excitement and indulging in obscene language. Her temperature ran up and her heart grew weak. She was put upon digitalis, eggs and milk every two hours. She gained in strength but her mental symptoms were unimproved.

Physical examination: Deeply lacerated perineum, lacerated cervix and prolapsed ovary.

Operation March 9th. Appendages removed. Great enlargement of ovaries of both sides.

In this case, hereditary taint was denied. Her menstrual periods were regular. While at home she was jealous of her husband's sisters. Was fond of drink, but had not access to much of it. Was indolent and careless. Was fond of talking about sexual matters.

After-history: Three weeks after operation, mental condition good, language to physicians chaste, appetite good. May 8th, 1892, was discharged from the hospital, recovered.

This woman up to the time of the operation used the most profane and obscene language Dr. Rohe had ever heard. When she recovered from the effects of the anæsthetic she burst into tears and asked the doctor's pardon for the ugly language she had used. She never afterward used any obscene or insane language to any one connected with the hospital.

In conclusion, Dr. Rohe said: I believe that in these four cases we have a contribution to the etiology of puerperal insanity. I believe that puerperal insanity is a phase of insanity that is due to absorption of septic matter, and when it is recurrent that it is the result of some reflex irritation due to an inflammatory condition in the pelvis or pelvic organs. All the cases which I have examined show some lesion of the genital canal remaining from parturition. The result of the treatment in these cases show this—that if cases are taken before structural alterations have taken place in the brain, before dementia has come on, that in the large majority of cases restitution of the mental faculties can be accomplished. There is another advantage, I believe, in this radical mode of treatment of this condition; that is, that a woman whose appendages have been removed will never have another attack of puerperal insanity at all events.

DR. WINSLOW: Are these selected cases? Are they all the operations which Dr. Rohe has performed for insane conditions since he had been at Spring Grove?

DR. ROHE: This is a series of cases due to one single cause. I have operated upon fifteen cases. In nearly every case there was some lesion of the pelvic organs. I expect to report all of these cases in the future. I believe that I will be able to report four or five as restored mentally. Nearly all have shown evidences of improvement. They are better patients;

they are not so disposed to soil, they can be kept on better wards with quieter patients. This is a decided gain for the management of the hospital.

WM. T. WATSON, M. D. Sec'y.

1519 Broadway, Baltimore, Md.

THE BIMANUAL SIGNS OF EARLY PREGNANCY.

Dr. R. L. Dickinson (*New York Journal of Gynecology and Obstetrics*) says:

The presence or absence of pregnancy may be determined in favorable cases by bimanual examination between the second and sixth week after coitus, or between the third and eighth after the beginning of the last menstruation.

Bellying or bulging of the surface of the body of the uterus is the most constant and valuable sign. It is rarely absent (4 per cent.) It may usually be found by the twenty-eighth day after coitus, although often present by the sixteenth or twenty-second day. Occurring most frequently on the anterior face (40 per cent.), it may appear on both, while in retroversion it is found posteriorly, and in certain cases laterally.

Elasticity or resiliency of the body of the uterus is more readily detected than the above, but less frequently present (80 per cent.). It is present, on an average, by the thirtieth day after coitus, but occasionally found by the sixteenth or twenty-first day. Usually it appears later than bellying.

Compressibility of the lower uterine segment (Hegar's sign) is less often found than the two preceding (66 per cent.); when it appears it may be fairly well defined by the twenty-fourth day after intercourse, but is often indistinct until the thirtieth or fiftieth. It is, therefore, a later sign than the preceding.

A traverse fold on the anterior uterine wall is usually distinct in the relaxed condition. Although infrequently found, this sign is of great value.—*The American Lancet*; *Cin-Lancet-Clinic.*

CORRESPONDENCE.

NEW YORK LETTER.

NEW YORK, Oct. 1892.

Though the excitement caused by the recent, near approach, and indeed the entrance of cholera into our country has passed away, and there is but little fear of its immediate return, it has started a train of argument in professional minds, as well as the minds of all thinking men, that should not be allowed to abate until some practical result is obtained. This train of thought is, how shall we prevent the entrance of infectious diseases into our land from foreign countries? This question does not interest those situated along the seacoast alone, but is of the deepest import to those living inland, for once let such a disease as cholera, typhus, or yellow fever get a foothold in one of the large seaport towns, quarantine as you will, you cannot prevent its spread from city to city and from State to State.

Much has been said *pro* and *con*, upon the administration of quarantine in New York during its late threatened invasion by the dreaded disease. It must be remembered that the true state of affairs in Europe had been concealed until the pest laden ships were almost in our port. The sudden emergency, therefore, arose when there was no time to prepare for it, and even when the disease was in our harbor, the majority were skeptical of its identity. Until Fire Island was obtained the ship cabins were the most comfortable quarters that could be had for the quarantined. Had the health officer asked the legislature for $200,000 to provide a quarantine station with last winter, does any one suppose it would have been granted? Or if it had been granted what a howl about deal, political corruption fund, etc., would have arisen. In this emergency it was only by the moral courage and intrepid bravery of a humanitarian governor that the means were put into the health officer's hands to abate the hardships of the quarantined. Though the laws enforced by Dr. Jenkins, at

times, seemed harsh or even cruel, it was the best that could be done under the circumstances, and, while we do not wish to be thought jesuitical, we think the end justified the means, and the question now is, how can we obtain as good results with less harsh measures.

The lively interest that is being taken in this question was evidenced at a recent meeting of the New York County Medical Association, where papers were read by some of the most prominent professional men of our country.

Dr. Chas. A. Leale read a paper on the subject of "Cholera, its propagation and treatment," in which he said that cholera is endemic in Hindoostan, and from there it travels to other parts of the world and after a time disappears as suddenly as it came. Why it should remain in Hindoostan and disappear from other countries so suddenly and completely, can no more be answered than why after a forest fire an entirely different species of tree will spring up; but why it spreads so rapidly in that country is explained by the fact that when an inhabitant is stricken with the dreaded disease he is placed in a little, poorly ventilated room and his friends gather around him simply to pray, without making the least effort at medical treatment, and without pretending to protect themselves or the patient from the vomit or discharge from the bowels. The disease is thus carried from house to house until it becomes epidemic. The germs of the disease are carried by transportation to other countries, through clothing and articles of merchandise, where they get into the water and food of the cities. Dr. Sternberg, in a recent paper read before the New York County Medical Society, said that there is little danger of the disease being carried through the mails, as after being dried the germ loses its vitality to a large extent. However, Dr. Dunham, at the meeting above mentioned, presented cultures of the cholera spirillum made from dry rags.

The cholera spirillum does not thrive in the gastric juice, but let it reach a stomach in which the acidity is diminished from any reason, and it immediately begins to grow, and passing into the intestines where the alkaline fluids favor its development, it multiplies rapidly, and the ptomains get into

the blood and cause the nervo symptoms observed. The vomiting and diarrhœa caused by the irritation of the germs, so reduces the serum in the blood that the heart's action is impeded.

If a case of cholera is seen in the early stage, it is often easily overcome, but unfortunately, it passes so rapidly from one stage to another that we do not frequently see it early. During the stage of collapse, the patient should be placed in a recumbent position and surrounded by dry heat, the heart stimulated, and the fluid in the blood increased by flushing the alimentary canal, through the rectum, with a weak saline solution at about 98 degs. F. For the cramps, alternately compressing and relaxing the limbs by grasping them with the hands is, according to Dr. Leale, the best method of treatment. He has seen patients recover after having been in a state of coliapse for four hours.

The physicians in Hamburg have found the best results, in extreme cases of collapse, to be obtained by the intra-venous injection of warm saline solutions.

Dr. E. K. Dunham gave a microscopical and stereoscopical demonstration of the cholera spirillum and the methods of cultivating it, the specimens and cultures being made from the cases which occurred in this city.

Drs. Godfrey and Gihon, of the U. S. Marine Service, spoke of the advantages of quarantine and the methods of conducting it.

Dr. Godfrey said that the object of quarantine was to destroy germs or to prevent their coming to a country. The latter method simply means to stop intercourse while the former would only retard commerce. The former method would be decidedly the best if we only knew how to destroy the germs of all infectious diseases. But we do not know this. Dr. Sternberg, probably the greatest authority in this country, says we do not know the germs of yellow fever and other fevers, and therefore, we do not know what will destroy them. Who knows but that the germs of yellow fever will thrive in bichloride of mercury and grow fat in sulphur fumes?

The ideal quarantine station is one equipped with the best

methods for disinfection, with a hospital for the sick and a house for the well, with a laboratory equipped for the scientific study of germs, so that we will not have to depend on the "guess work of clinical symptoms" for diagnosis, and manned by scientific workers not appointed by political poll, and subject to removal at every election, but by competitive examination, to hold office during life or good behavior. Such a quarantine office, supported by the United States government, would serve to prevent, or at least to diminish, the annual visitations of yellow fever in the Southern States, and exclude the dangers of cholera, typhus fever and other infectious diseases entering our country. But unfortunately, quarantine is looked upon by many, in a purely mercenary manner, and they raise the question, "which will cost the most, the cessation of immigration and commerce for a time, or an epidemic?" and as those in power think that the danger is but slight for them, they decide that the epidemic is the least expensive, until one of these little insignificant germs finds it's way into his household, and then, too late, he changes his mind. But says Dr. Godfrey, "I wish you to understand that I consider the life of an individual of more value than all commerce."

Dr. Smith read a paper on choleraic diarrhœa in infants, in which he stated that during a cholera epidemic, it is often quite impossible to say, without a microscopical examination, whether or not a given case is cholera infantum or Asiatic cholera. He attaches but little importance to the rice-water stools in such cases.

At a recent meeting of the Section in Public Health of the New York Academy of Medicine, the cholera question was minutely discussed. In a paper by Dr. Joseph H. Raymond, the efficacy of sulphur dioxide as a disinfectant against the cholera spirillum, was discussed. He presented statistics from the experiments of Drs. H. M. Biggs, L. H. Thoinot and M. Masselin, which showed that SO is an efficient disinfectant against the cholera spirillum. It should not be used, however, to the exclusion of bichloride and other antiseptics, but should follow their application. After an infected room has been cleansed with a 1-500 solution of corrosive sublimate, all the openings being carefully closed, it should be

fumigated for several hours with S O, when it will be impossible to make a culture of the cholera germs from articles or scrapings from the room.

At the annual meeting of the American Orthopedic Association, Dr. H. Hodgen, of St. Louis, reported a case of adduction of the foot, following fracture of the neck of the femur. The case illustrated, in a marked manner, the difficulty of diagnosis in some cases, between fracture of the neck and dislocation of the head of the femur. It was treated by extension and a double-inclined plane.

Dr. H. A. Wilson, of Philadelphia, stated that the changes in the structure of bones, often described in club-foot, are, to a large extent, due to postponement of appropriate treatment. This may be accounted for in either of two ways. First, where the process of ossification progresses while the tarsal bones are partially dislocated, they become permanently deformed to suit the abnormal position of the foot; secondly, where recourse has been had to mechanical force to stretch the shortened tendons, the bones, whether deformed or not, yield to pressure, and thereby become deformed. He formulated the following principles:

1. Full, perfect correction should be obtained during the first month.

2. When correction is possible, without recourse to rigid restraining apparatus, tenotomy should be avoided.

3. Tenotomy, syndesmotomy, or cutting of the fascia, should always be resorted to within the first month, when perfect correction cannot otherwise be obtained without undue force.

4. Tenotomy should never be resorted to in infancy, without being followed by developmental and restraining treatment.

5. It is misapplied mechanics to force club-feet into rigid restraining shoes and doing so in the first three months of infancy, will produce bone deformity.

6. All apparatus employed in infancy, should facilitate free motion in the proper direction, and encourage the development and correlation of muscular force.

7. All methods which employ undue force in correcting or

restraining club-feet, should be refrained from until the child has reached the age when bones are completely ossified. The same period should be reached before resorting to operations upon the bones.

Dr. J. E. Moore, of Minneapolis, reported six cases of excision of the knee joint, in which the incision above the patella was used, and the patella removed. Drainage tnbes were not recommended. The bones were united by four steel wire nails. The plaster of Paris dressing extended from the toes to the body, and was not changed for one month.

At a recent meeting of the New York Pathological Society, Dr. J. S. Ely demonstrated, under a microscope, the amœba dysenteric in ulcers of the colon, and in an abscess of the liver. The demonstration was particularly interesting as it is the first time these amœba have been demonstrated in the tissues, though the whole subject has been carefully worked up and described by Drs. Councilman and LaFleur, of Johns Hopkins University. The speaker said, that on a previous occasion he had found the amœba present in the stools of a patient. The specimen had been stained with the ordinary stain of hæmatoxyline and eosin.

The study of the life history of this germ, it's viability, what medicants will destroy it, and whether or not it will cause dysentery when placed in a healthy alimentary canal, is an interesting field for investigation. T. D. T.

REMEDY FOR STERILITY—Dr. Gritian, of Lyons, knowing the intimate connection existing between the uterus and the larynx, always told us in his lectures: "If ever you meet a woman complaining of infecundity, tell her to sing at the top of her voice during the copulative act, or the actus conjug; it is the best method of promoting conception." I gave this advice on two occasions to friends, and it proved a success, although one of them had a pair of twins. She told me, after that experience she kept her mouth shut.—*Medical Times.*

Selections and Abstracts.

SOME REMARKS ON THE VALUE OF VEGETABLE ALTERATIVES IN CHRONIC, VENEREAL, TUBERCULAR AND MALARIAL DISEASES.

BY THOS. H. MANLEY, M. D., NEW YORK.
Member of N. Y. State and County Medical Associations, American Medical Association, Visiting Surgeon to Harlem Hospital, etc.

Speaking of the elements of those medicines which serve a useful purpose, in exhaustive and debilitating diseases, Dr. Manley says, that there are limitations to the province of physiological chemistry or bio-chemistry, in being able to satisfactorily explain the *modus operandi* of very many of our most valuable medicinal agents. This is particularly true of the vegetable tonics, when administered in wasting diseases. We may prescribe iron, arsenical, quinine or other salts in malarial, tubercular, or syphilitic anæmia, occasionally, in vain, when, if we place our patient on fresh infusions, decoctions or tinctures, immediate benefit will follow. The profession is not by any means in accord with those who would have us believe that the time has arrived, when medicines can be prescribed according to any set of rules, whatever scientific basis their construction may rest on.

Warburg's tincture, one of the most valuable anti-malarial remedies known, unfortunately is a secret, quack remedy, though owned by the British government. Huxam's tincture, so long a secret compound of the Birmingham chemist, is now common property of the profession.

Cod-liver oil and its many preparations have held their own well in pulmonary tuberculosis. But, there are many phases of surgical tuberculosis and those conditions of malnutrition resulting from syphilis, in which the oil is not well borne. Here the vegetable tonics, particularly those rich in the alkaline salts, are invaluable. The tincture of hops, decoction of sarsaparilla, gentian, columbo, or chamomile, either

may be taken alone or in combination. A valuable combination of herb extracts was elaborated in the Southern States by members of the medical profession, as a substitute for mercury and the potassium iodide, during the late war of the rebellion, when all pharmaceutic supplies were shut out by the blockade and the advancing lines of the enemy. It is known to pharmacists and practitioners as Verrhus Clemiana, and is composed of Clematis-erecta, Prinus-verticillatus, Fraxinus Americana, Rhus-Glabrum, and one-eighth of one per cent. of Venanatic acid; all indigenous in the Southern States. I have extensively employed this compound in many cases of chronic, tubercular, glandular and bone diseases, besides other wasting maladies, with excellent results. Indeed, in these times, pharmacy yields a large number of vegetable elixirs, so palatable and easy of assimilation that one should always give them a protracted trial in the vast majority of tubercular or syphilitic, bone or joint disease, before any sort of sanguinous operation should be thought of.—*Doctor's Weekly.*

TURPENTINE IN TYPHOID FEVER.

H. C. Wood believes that when, in the convalescence of typhoid fever, the existence of local intestinal symptoms points toward slowness of healing of the ulcers, turpentine is an invaluable remedy. It is also indicated when there is marked typanites, with dryness of the tongue, developing in the end of the second week of typhoid fever. The action of turpentine is believed to be a local one upon the ulcerated surface. The terebinthinates are slowly absorbed, and, indeed, volatilized at the temperature of the stomach and intestines, and we readily believe, from the result of the laboratory researches, that there is a special relation between the oil of turpentine and the bacillus of typhoid fever (Omelchenko). This practice has been in vogue for more than half a century, and the author believes that it is a good one, and distinctly tends to lessen the severity of the local lesions in enteric fever. The formula recommended is oil of turpentine, 1; glycerin, 4; mucilage of acacia, 6; peppermint water to 32. The dose is

one teaspoonful every four hours during the day.—*Therapeutic Gazette*, 1892, No. 6, p. 366.

[This sound practice, based upon intelligent empiricism of half a century ago, has recently received support from the results of laboratory experiments, and is now placed upon a scientific basis; and it is likely to outlast many of the modern methods now so much in vogue.—R. W. W.)—*American Jour. Med. Science*, Oct. 1892.

THE PROPER METHOD OF APPLYING OBSTETRIC FORCEPS.—1. Anesthetize the patient and place her in proper position—buttocks well over the edge of the bed, and each limb supported by an assistant.

2. Ascerting the position of the head, introducing within the vagina two or three fingers, or if necessary the whole hand.

3. Apply the blades of a Hodge type of forceps to the sides of the head, with the concave edge directed toward the occiput. If for any reason this cannot be accompliahed, withdraw the instrument and substitute a Simpson (or Elliott) passing the blades to the side of the pelvis. While making traction with this method, watch for anterior rotation of the occiput, and encourage it in some cases by re-applying the blades to better advantage.

4. Make every effort to secure antiseptic condition during the operation. The fingers, hands and forearms of the operator, the external genitalia and vagina of the patient, the instruments and the hands of the assistants, should be clean and aseptic.—*Amer. Jour. Obstetrics.*—(*Medical Breef.*)

CHLOROFORM IN PARTURITION.—In the *Med. and Surg. Reporter*, Dr. L. Ridgeway Barber discusses ably the question of administering chloroform in labor to women who have organic heart disease. He concludes that chloroform by inhalation can and will, if properly administered, save the lives of parturient females, suffering from organic disease, when death seems imminent from overstimulation of its ganglia through reflex nervous action. Organic heart disease, then, does not preclude the use of chloroform in labor, but rather is a condition calling for its careful administration.

Editorial.

SURGICAL RELIEF FOR BILIARY OBSTRUCTION.

The recent improvements in surgical procedures, connected with the gall bladder, are among the most notable advances in the operative measures adopted of late for the relief of abdominal troubles.

That system of ducts which connects the liver with the gall-bladder and alimentary canal performs such important functions in health as to render a knowledge of them essential for a proper comprehension of the disorders incident to their temporary arrest or permanent occlusion.

A division of these conduits into the small biliary tubules, the hepatic, cystic and common ducts is generally recognized, and any interruption in their discharge of bile demands correction.

To give surgical relief for biliary obstruction, all the surroundings of the case must be clearly defined. With a view to the proper diagnosis of disorders involving the gall-bladder, all tumors connected with the liver call for careful examination. Any purulent collection in the parenchymatous structure of this organ, extending below the margin of the ribs on the right side, may be mistaken for a distended gall-bladder. On the other hand, the dilated sac may give the impression of hepatic abscess. In the event of the extension of the elongated tumor, from dropsy of the gall-bladder, into the iliac region, it may be taken for an enlargement of the ovary with fluid contents. The element of fluctuation does not avail for a differential diagnosis; but in the absence of any well defined induration around the border of the tumor and its reaching up under the costal arch, it is a fair inference that the gall-bladder is involved. If along with local signs there is evidence of obstruction of the common duct in the appearance of jaundice, or the absence of bile from the fæcal evacuations, it will still further strengthen the presumption in favor of an accumulation, either of bile, a clear mucus, or a

sero-purulent fluid in the gall-bladder, and thus contribute towards a correct diagnosis.

In the consideration of different methods of operating on the gall-bladder, it is preferable to commence with that of most gravity and then proceed to others of less seriousness, under the following classification:

Cholecystectomy, or excision of the gall-bladder; cholecystotomy, with or without the formation of an external biliary fistula; duodeno-cholecystostomy, or the formation of a direct communication between the gall-bladder and duodenum.

Cholecystectomy indicates the incision of the walls of the gall-bladder or the extirpation of this sac with ligation of the cystic duct.

The peculiar arrangement of the several ducts by which the bile is conveyed from the secretory apparatus of the liver into the gall-bladder, and thence discharged as occasion may require, may be supplemented by its direct passage. In the event, therefore, of complete occlusion of the cystic duct, while there is no restriction of the direct passage, it becomes utilized without this diversion of the bile into the gall bladder.

A pre-requisite for differentiating the conditions warranting extirpation of the gall-bladder from those derangements in which other modes of correction are available is a thorough comprehension of the normal functions of the gall-bladder, with a minute examination of all the consequences of obstruction of the ducts, and the feasibility of the various measures of relief which have been proposed or put into execution on the human subject.

An incision of the linea alba, between the ensiform cartilage and umbilicus, of sufficient length for convenient manipulation, or over the line of the tumor beneath the arch of the ribs, will expose the diseased gall-bladder, whether it be distended or not. If there is a fluid of any kind accumulated in its cavity, this should be let out by puncture with a trocar, and then incision of the sac as near the margin of the liver as practicably will admit of the removal of any solid contents, with an exploration of the cystic duct. Excision of the walls of the gall-bladder, or a careful dissection of its attachment

to the liver, with ligature of the cystic duct if permeable and the subsequent closure of the external wound by suture, completes one of the most rational and effective proceedings in surgery.

We must be guided in our decision of its merits, by the judgment of those whose practical acquaintance with the details of the operation entitles them to recognition as authorities in the matter, and it should not be condemned without a thorough investigation of the grounds upon which it is undertaken. Criticism of this operation from any other standpoint than that herein presented, is short-sighted and unwarrantable, since the facts must be accepted in their true significance, as the basis of forming a correct judgment. The legitimate fruits of an impartial consideration of the cases of extirpation of the gall bladder, which are now brought to light, must soon be apparent with the advance of surgery.

It is clearly shown that the gall-bladder is not indispensable to the regular performance of digestion, and it is not infrequently found completely occluded and atrophied, while the bile is conveyed directly into the duodenum, so that Thiriar regards cholecystectomy as the least dangerous of all the operations.

We had to chronicle eleven additional cases of cholecystotomy shortly after the table of thirty-three cases was published in the Reference Hand-book, there being eight successful cases reported by Tait, two unsuccessful by Parks, and a successful case for each by Carmalt and Hutchison. All these operations were done by attaching the opening in the gall-bladder to the wound in the parietes, so as to allow of drainage externally, with a view to a temporary biliary fistula, but expecting their closure subsequently. Quite a large number of these cases have been reported within the past few years.

The complete success of Tait's operations upon this principle, and the satisfactory results of attaching the vesical incision to the external wound in the hands of a number of other operators, has to a large extent redeemed this measure from the imputation of entailing upon the patient the grave consequences of a continued drain of bile from the system. In cases, therefore, which afford a reasonable prospect of a re-

establishment of the flow of bile into the duodenum, this means of giving an outlet externally to the contents of the gall-bladder, until obstructions of an organic or mechanical nature may disappear, commends itself to the adoption of surgeons, but it is not suited to cases of complete occlusions.

Duodeno Cholecystostomy.—This term indicates an operation for uniting the gall-bladder and duodenum, with an opening between them for the passage of the bile. It is only applicable in cases of permanent occlusion of the common bile-duct, while the cystic duct is permeable, or may be opened by surgical means, and the sac has not undergone degeneration.

If there is satisfactory evidence of such agglutination of the walls of the common duct as to render this canal incapable of conveying the bile into the alimenary tube, we may undertake to substitute an abnormal for the normal route of the bile, by a direct cysto-duodenal communication. This is not a circuitous channel from the liver into the intestine, since a large portion of bile flows ordinarily into the gall-bladder, and by this new outlet it will pass immediately into the duodenum. The operation proposed by Gaston for effecting a union between the walls of the gall-bladder and duodenum, with an opening from the cavity of the former into that of the latter, consists in connecting them by suture with a single stitch, which shall unite their surfaces by adhesive inflammation and cut an opening between them, passing off in the intestinal canal. Others have used different processes since.

The prime consideration in determining upon a resort to cholecystectomy, cholecystotomy or to duodeno-cholecystostomy is the comparitive integrity of the structures involved in disease of the gall-bladder from biliary obstruction. If there should exist such an impairment of the vitality as to threaten disorganization of the tissues of the sac, excision or extirpitation would be preferable to any operation for preserving an outlet for the bile, either by an external opening or by a communication with the duodenum. If the conditions warrant a conclusion that the normal communication between the gall-bladder and the alimenary canal can be restored, cholecystotomy would be justifiable. But in case of permanent obstruc-

tion of the common bile-duct, without such obstruction of the cystic duct as to afford an irremediable impediment to the entrance of bile into the gall-bladder, duodeno-cholecystostomy is the most feasible proceeding. Permanent occlusion of common duct warrants a direct outlet from the gall-bladder into the duodenum. In the event of an apparent obstruction of the cystic duct, it is usually complicated with accumulations within the sac, of inspissated bile, of mucus, of pus, of seropurulent fluid or of gall-stones. The removal of the contents of the gall-bladder and the impediment from the duct, devolves upon the surgeon before undertaking to connect the gall-bladder with the duodenum. This may be done by an incision of limited extent, so that it shall be sutured to an incision of the duodenum or the jejunum and thus secure their union and the passage of the bile into the intestine instead of being discharged externally. It is proper under other circumstances to evacuate the distended gall-bladder externally, and suture the incision separately with a view to establish another communication between it and the canal, which is requisite for a successful result in any case.

When the diagnosis of distension of the gall-bladder can be made out, as most frequently it can, upon a thorough manual examination connected with the history of biliary obstruction, it is preferable that an abdominal incision be resorted to as a preliminary step to whatever exploration by the eye, hand or instruments may be requisite for completing the operation. Should it be found practicable to free the tract of the cystic-duct while the common duct remains impermeable, the proper recourse consists in a direct cholecysto-duodenal outlet for the bile into the alimentary canal.

A number of operations have been performed in which the gall-bladder has been connected with the small intestine and the colon. The most satisfactory results however, have been secured by the union with the duodenum.

The common bile duct has been united to the intestine in a few cases, but this operation is attended with difficulties which are not encountered in effecting a communication with the gall-bladder.

The removal of the biliary calculi from the ducts by incision of the walls and then closing the opening by suture, has also been resorted to for freeing the canal of their obstructions.

This simplifies the duties and responsibilities of the surgeon exceedingly; but how shall the fair patient, more terrified by the risk of disfigurement than by the pain of her injury, look upon what may well seem to her such doubtful resources of the surgical art. It is but poor comfort to tell her that, if her teeth do not grow more or less in place, the dentist can by-and-by fill the gap with artificial ones. It needs not that the patient should be a woman to cherish the natural teeth as far preferable to the porcelain kind; and it does seem to me that the method proposed does not give him that relative guaranty of perfect repair to which he is entitled. The pressure of the lower teeth against the upper fragment does not always retain it in position when once placed there. If the displacement is backward, as it almost always is, the retentive dressing should carry the lower jaw forward, as well as upward, to hold the opposing incisors in contact. But the Barton and all similar bandages carry the jaws upward and backward, a function which Agnew later on recognizes and avails himself of in the dressing he proposes for fracture of the inferior maxilla.

Neither these nor other writers neglect to mention the Gumming interdental splint and its various modifications, or other more or less complicated and difficult dressings, in the more serious fractures; but all rely too much upon the well known reparative power of the upper maxilla to remedy the damage with but little help, when the damage is confined wholly or mainly to the alveolus. They would seem to be satisfied with union of the fracture, which is easily attained, even if the position is not entirely perfect.

That we can almost certainly secure a perfect result, not only functionally but cosmetically, I think will be shown by the following outline history of a case:

Miss O., age 12, was accidentally struck in the mouth by a croquet mallet, the blow fracturing the upper incisor alveoli, producing backward and downward displacement of the central teeth to the distance of nearly one-fourth of an inch. Firm and steady pressure, continued for some minutes, brought the piece nearly but not quite into position; but soon separation returned when pressure was removed.

The treatment employed was the customary one of bring-

ing up the lower jaw and bandaging in firm position. I was sorry to find the next morning that the fragment was not in place; and then my patient told me that as there was some pain she would often draw the lower jaw back for the comfort it would afford. This could be done to the extent of one-fourth of an inch, and in spite of the bandage, the jaw could be depressed quite as much. Foreseeing that a perfect result could not be got in this manner, I had an impression of the fractured jaw taken, and a vulcanite splint made to fit. Dr. Tinker, a dentist of our city, did this with great skill; and when it was applied, the suction or atmospheric pressure was sufficient to hold it in position, as a plate of artificial teeth is held. It is likely that this force could have been quite sufficient from the first, but it seemed best to give the additional security of the lower jaw bandaged up for a few days, especially as coaptation was not at once exact, and continued firm pressure seemed necessary to complete it.

At the end of three days the splint was carefully detached, and the contour of the dental arch found to be exactly restored. After this the bandage was dispensed with entirely, and at the end of four weeks union in position was perfect.

It is not unlikely that others have, in the treatment of such fractures of the upper jaw, availed themselves of the retentive force of atmospheric pressure; but in such literature as has been accessible, I have not found any record of it. For this reason, my own case seemed deserving of a report; for, if not unique, it may direct attention to a method which, to say the least, should be more generally recognized and employed.

Perhaps the question may be raised as to the necessary size or superficial area of the palatal plate of such a splint. For limited practices this need not be great. The one I used did not exceed three-fourths of an inch in breadth and was consequently horse-shoe shaped. Less might have sufficed for the pressure over two square inches where the fit is exact, and the air underneath well exhausted, is a strong retentive force, as you will readily perceive. There might, however, be the necessity for embracing the whole hard palate; though it is doubtful if the retentive force would be proportionate to the increased area, owing principally to the increased difficulty of securing an exact fit.

In the usual form of fracture with inward displacement, the dental groove in the splint is not a theoretical necessity; but for precautionary reasons it would be better to have it; if not for the purpose of greater security against accident, at least to provide against the contingency of an ill fit when it could be made to serve the purpose of an ordinary interdental splint. It seems probable, however, in cases where the fit is not primarily good, that nature may, after a day or two, come to the aid of the dentist, and then dam the leaky places in the palate process with swollen tissues.

GONORRHŒA IN THE FEMALE.*

BY R. R. KIME, M. D., ATLANTA, GA.,
Lecturer on Gynecology in the Southern Medical College.

Not long since gonorrhœa in the female was considered of very little consequence, but later, as we learned more of its characteristics, nature and results, the opinion has been reversed. In its direct and remote results it is one of the most serious diseases we have do deal with in the female.

It is a specific contagious disease, usually transmitted by the male; due to a specific germ or micro-organism called the gonococcus, discovered by Neisser in 1879. It is a diplococcus of different characteristics, microscopically and clinically, from the different varieties of staphylococci and streptococci.

The presence of gonococci in secretions is diagnostic, although their absence in some instances does not disprove it to be the specific element in conveying the disease. It has been demonstrated that the gonococcus has the power to penetrate pavement as well as cylindrical epithelium, and it is also claimed that they can penetrate connective tissue and infect lymphatics. Their presence in the pus of ovarian abscesses and pyosalpinx has been demonstrated, yet they may be absent in these conditions, having run their course, died and disappeared, leaving the pyosalpinx as a result of its ravages.

The source of infection in the female is usually from the

*Clinical lecture delivered before class.

male, yet young girls may contract it from the mother or nurse while caring for them. The course, duration and termination of the disease is influenced by the character of virus introduced, location of infection and characteristics of individual infected. The virus from an acute, active, virulent case is more likely to produce an acute, active, invasive inflammation, running its course more rapidly, especially in subjects with genitalia in condition to form a proper nidus for development of the gonococcus. The virus from a sub-acute, chronic, or what is known as the "latent form," is more likely to run a slower, less active course. In either case, if the patient is of that strumous variety, subject to catarrhal conditions, with genitalia already in an abnormal condition, we may expect more serious results from the infection. Just here I might say he who treats gonorrhœa in the male and fails to warn his patient of the dangerous results in the female of sexual intercourse before he is *completely* cured, or gives consent for marriage before he is thoroughly satisfied that his patient is completely cured, is culpably negligent and derelict of his duty. "The noblest of God's creation, a pure woman," should not be made to suffer for the vices of a man and ignorance of the doctor.

Gonorrhœa may affect the vulvo-vaginal glands, urethra, vagina, uterus, tubes, ovaries, pelvis, peritoneum, and even the rectum. When these different structures become involved, they manifest the usual symptoms of acute inflammation of the several structures. There may be more than one part affected simultaneously, but usually the infection occurs at one point and invades other organs.

It is very difficult sometimes to distinguish a simple vulvitis, vaginitis, urethritis, etc., from specific infection of these organs. In fact, in some cases, the differential diagnosis can only be determined by the presence of the gonococcus. The infection may occur from the male suffering with a latent or chronic form of the disease, in which the virus is deposited high up in the vagina, affecting this point and extending from thence upward without ever involving vulva, urethra, etc. It is thus males often contract gonorrhœa from apparently healthy females, also where the disease is yet lurking in the

vulvo-vaginal glands and forced out at sexual intercourse by contraction of bulbo-cavernosa muscles. These militate against the idea of requiring all female prostitutes to be examined to prevent conveying the disease.

The symptoms from this variety of infection may be very misleading as to what would ordinarily occur from gonorrhœal infection. There are such few special manifestations of acute specific inflammation that the disease may be scarcely recognized, and may run its course without hindrance, gradually involving the lining membrane of cervix, uterine body and fallopian tubes, producing pyosalpinx and pelvic peritonitis. It is said the cervix furnishes a favorite abiding place for the gonococcus; that if not molested it will live there for months in luxury, exercising its reproductive functions.

From an infection by virus from the more active acute form we would naturally expect more active inflammation, with more rapid involvement of tissues. Then we would have all the symptoms of acute inflammation manifested in accordance with tissues involved. Thus we might have the characteristics of active acute vulvitis, urethritis, vaginitis, and later endometritis, salpingitis, ovaritis, and even pelvic peritonitis, and as a result of such inflammation, we may have pus accumulate in the fallopian tube (pyosalpinx), or abscess of the ovary.

The cases we have had before the class are instances of a mixed infection according to the latest investigations in bacteriology and pathology. They are instances of gonorrhœal and chancroidal infection, the gonorrhœa having produced a specific vulvitis and vaginitis in each case, and if not controlled by the plan of treatment which we have adopted, later on may develop endometritis and salpingitis, with its consequent results. The chancroidal infection has produced the characteristic chancroids in each case, appearing successively multiple in number, which precludes chancre of syphilis. If multiple, all appear simultaneously. You understand by chancroidal infection that it is a local specific, infectious disease, and not constitutional; that the specific germ has not yet been isolated. This subject will be lectured on later in the course.

In one of our cases we have the rheumatic condition, which

is occasionally the result of gonorrhœa, and called gonorrhœal rheumatism. Recognizing the tendency of gonorrhœal inflammation to invade new tissue, you can readily understand how a specific urethritis may develop a gonorrhœal cystitis, which will be lectured on by your able professor of genito-urinary surgery, Dr. Elkin.

We have taken up this subject and dealt with it somewhat collectively from a clinical standpoint. You will be surprised in looking over your gynecological text-books not to find gonorrhœa dealt with to any great extent; not to the extent its importance demands. What you do find will be under the head of local specific inflammation, such as vulvitis, urethritis and vaginitis.

In the treatment of gonorrhœa, briefly considered, we would advise the same general plan for specific urethritis in the female as in the male. For specific vaginitis, thorough cleansing with hot douches, followed with mercuric chloride, 1 to 2,000 or 3,000, well applied; then coat mucous membrane freely with dry boracic acid, and introduce a loose tampon of gauze or absorbent cotton. If preferred, you may apply nitrate of silver, gr. xx to oz. j of water, or comp. tr. iodine and glycerine, equal parts, followed by a tampon of glycerine and boro-glyceride on absorbent cotton. Iodoform gauze may be substituted as a vaginal tampon after either of the above applications. In these cases cleanse cervix well, and close it with iodoform gauze, to prevent extension of disease to cervical and uterine cavity. When it has reached the uterine cavity, dilate cervix with steel dilators (not tents), irrigate at once with mercuric chloride (1 in 2,000), holding cervix open with dilators to allow free return of fluid; then curette to remove coating of albuminate of mercury and dislodge any gonococci buried in uterine lining membrane. After running curette over all the interior of uterus, again irrigate with mercuric chloride, observing same precautions as to escape of the fluid; then tampon with iodoform gauze, with or without an application of carbolic acid, iodine or nitrate of silver to the endometrium. Renew the tampon and applications to endometrium every second or third day until the disease is under control.

If the disease reaches the fallopian tubes, treat as an ordi-

nary salpingitis. If it results in pyosalpinx, which is very likely to occur, then you have the train of symptoms indicative of pus in the tubes, with occasional attacks of local peritonitis. The relief of this condition in the majority of cases will require the removal of the diseased tube. It is advisable in such cases to always remove both tubes unless you are certain one is not diseased, and that you have eradicated all vestige of the disease and gonococci in the uterine mucosa. If the disease has not been entirely cured, all gonococci destroyed, the disease is very liable to extend to the apparently healthy tube and require a second operation. Some of these cases can possibly be relieved by vaginal drainage. It is only advisable, however, when the pus tube is adherent to vagina, and not sacculated, that is, where it has but one cavity with no constricted portions to prevent free drainage. Neither of these cases can be successfully relieved by drainage into uterine cavity. It is best not to temporize with ineffectual measures for relief, but resort to the knife.

Correspondence.

OUR NEW YORK LETTER.

NEW YORK, November 17, 1892.

Though the treatment of typhoid fever by the cold bath is by no means a new subject, some remarks on the results of its use in the New York Hospitals, as well as a brief outline of a method by which it may be given in any private house, and a means of treating hemorrhage from the bowels, may be of interest to some of our readers.

Notwithstanding the fact that cold was used by the ancients in the treatment of fevers, it was not until 1861 that Brand, of Stetten, started it on its new era in the treatment of typhoid fever by introducing the method of which I shall speak. Though the objection is urged against this method that it requires too many attendants and too much paraphernalia for use in private practice, the members of a household are more than glad to thus exert themselves when, after a bath, they

see the sufferer with bright eyes and intelligent face, instead of the glassy eyes and delirium disturbed countenance; and by a method which I shall outline the paraphernalia is reduced to such an extent that it can be had at a moment's notice.

In all cases where the cold bath is used the results are most pleasing, but where the method recommended by Brand is employed, strictly according to his directions, the results are simply astonishing. Up to the time when he introduced this method the mortality in typhoid fever ranged from 20 to 40 per cent., but during seven years of this treatment by Brand, Vogl, and their cogeners, the mortality averaged 2.7 per cent., and in 1,223 consecutive cases treated by them only 12 died, but in these cases his ideas were carried out minutely, and they did not hesitate to give a bath to any case that resembled typhoid because they were not sure it was a correct diagnosis. Vogl, during his forty years experience in the Garrison Hospital at Munich, saw all the different methods tried that have been advanced in this time, but none of them ever reduced the death rate to any marked degree until the cold bath was introduced, when it suddenly fell so low that to-day the statistics are received by many with a question mark.

Any treatment that will so reduce the mortality of a disease, let it be heroic or what not, should have the most careful consideration of the profession and given a thorough trial before it is dismissed, as too many are disposed to do, as impracticable. The words of H. C. Wood should certainly induce the profession to investigate their foundation: "I have no doubt that many persons have died in the United States from typhoid fever whose lives might have been saved by Brand's method if the American medical profession had risen above the opposition of the laity and above their own prejudices."

If the physician is thoroughly convinced that this is the best and safest method of treatment, the laity will follow his directions, but if he says, "I think a cold bath might do the patient some good," the patient will not get one, for it requires the persuasion of self-conviction to induce the friends of the sufferer to give this treatment. The first few baths must be administered by the physician himself, for the com-

plaints of the patient will overrule the judgment of his friends, for until they see the good effects of the bath, it appears to them to be a cruel treatment.

One point insisted on by Brand is that the baths must be begun as early in the disease as possible; as soon as typhoid fever is suspected start the bathing, and if it does not turn out to be typhoid no harm is done, and in some cases good has resulted; even in cases where typhoid was suspected, which were really pneumonia, baths have been administered with no bad result. Several cases of this nature have been reported by European writers, and one was presented in the clinics at New York Hospital last winter in which the patient recovered promptly, though he had several baths.

The temperature of the bath should be from 65 to 68 deg. F., should be given every three hours if the patient's temperature is at or above 102.2 deg. F., and continued ten to fifteen minutes. While the patient is in the bath, water at about 55 deg. F. should be frequently poured over his head, and the extremities and body should be rubbed vigorously by attendants, while the patient is encouraged to rub himself, thus causing an alternate contraction and dilatation of the arteries keeping the cold water in constant contact with all parts of the body, and stimulating the superficial nerves.

When the temperature ranges from 101 degs. to 102.2 degs. F., cold packs should be applied to the abdomen at a temperature of 65 degs. F. and changed every half hour if the patient is awake.

The *rationale* of the cold bath is minutely described in a series of papers in the *N. Y. Med. Journ. '89-'90.*

The effect of the cold bath treatment is not simply reduction of the temperature; indeed this is the least of its effects; it refreshes the nervous system, deepens the respiration, moistens and cleans the tongue, improves the appetite, steadies and slows the pulse, increases the excretion of urine, and removes stupor and delirium.

When the cold bath method is being followed, no other treatment should be used, except that of feeding the patients. They should be given veal, mutton or chicken broth, which has been allowed to cool and the fat removed, or milk with a

little extract of malt in it. Alcoholic stimulants should be given when the condition of the patient demands it, and in most cases, just before he is put in the bath and after he is taken out.

In considering the result of any form of treatment in typhoid fever, we must know the character of the epidemic, for in some epidemics any treatment seems to give good results, while in others, the cases seem to die in spite of all treatment. The work of Vogl, extending over a period of forty years, observing every form of treatment that has been advanced, and especially the cold bath method, furnishes the results of this treatment in every form of epidemic from the mildest to the most severe.

In hospital practice, the results of the cold bath treatment can be justly estimated, for the patients do not present themselves until they are well along in the disease, usually near the end of the week, and one of the requisite points in the treatment is that it be begun early, which can be accomplished much better in private than in hospital practice. Notwithstanding this fact, the results of this method even in the hospitals are very gratifying. In New York hospital during the the year ending Nov. 1st, 1892, there were 76 typhoid patients treated by the cold bath with a mortality of only 5 per cent.

The Brand method was carried out more perfectly in this hospital than in any other in the city, as in most of them they mixed the treatment; in some, giving a bath when the patient seemed to stand the high temperature poorly, and in others, giving baths together with intestinal antiseptics and other medication, but in none have I been able to find as good results as those given above.

Granted that the tub-bath is by far the best method of administering cold in typhoid fever, it has at least two serious disadvantages for use in private practice. First, it is rare that a tub suitable for this purpose can be found in a private house, for it must be a full-sized bath tub that can be moved to the side of the bed, and second, when the patient is delirious he makes a great fuss about being put in the tub, and the members of the household, being unable to appreciate that he is partially unconscious, think he is being treated inhumanly,

and the result is the treatment is discontinued, either with the physician's consent, or by a new doctor taking charge of the case. The first of these objections is easily overcome, and the second greatly disminished by the following method, which in want of a better name, I will call the "bed bath."

This method is very simple and the articles necessary to carry it out can be found in every house or at a country dry-goods store. A rubber sheet, large enough to extend well over the sides and ends, is placed over the bed, under the patient, and four blankets are made into rolls and placed under the sheet at the ends and sides of the bed, thus making a rubber bath tub, in which the patient lies, deep enough to about two-thirds cover him. Attendants are at hand with vessels of water at 65 deg. F., and sponges or bunches of gauze with which they apply the water, by a gentle slapping and rubbing, to all parts of the body, until the tub is filled. Pieces of ice, wrapped in gauze to prevent their coming in contact with the patient's body, are placed in the water to keep it at the de-dired temperature. This bath is continued for fifteen minutes, when the water is removed by siphon or sponges, the sheet and patient are wiped dry, and the latter wrapped in a linen sheet, and, if shivering, a light blanket is thrown over him. This method is used in one of our best hospitals with cases, where, for any reason it is thought best not to lift them from the bed to the tub, and, though not quite so marked as in the tub-bath, the fall of temperature is very decided, 1.5 deg. F. to 2 deg. F., and the other effects are practically the same as in the tub-bath. There seems to be something less fearful to the patients' minds, in this form of bathing than in the ordinary tub-bath, for they rarely object to it more than to the ordinary sponging with alcohol.

Hemorrhage from the bowels is not a contra-indication to this form of bathing; in fact, it is in cases of hemorrhage that this is most frequently used in the hospital. In cases of severe hemorrhage, it is rare that a bath is called for, as it is the rule for the temperature to fall and not to rise again to the bathing point, though the patient often recovers.

A unique method of treatment in cases of hemorrhage from

the bowels, is that of "tieing off" the limbs, now in use in our hospitals with most beneficial effects. This consists in passing an elastic band with a buckle on it, (a piece of suspender will answer admirably), around each of the limbs close to the body. These are tightened sufficiently to check the venous return and yet not obstruct the arterial flow, thus keeping a large amount of blood out of the trunk, and thereby greatly lowering the pressure in the intestines. At proper intervals, to be determined by the condition of the limbs, one band at a time is loosened sufficiently to permit free circulation for about ten minutes, and then tightened again. This is continued for several days, depending on the severity of the hemorrhage.

35 West 45th Street. THOMAS D. TUTTLE.

Society Notes.

SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION.

Fifth Annual Meeting, held in Louisville, Kentucky, November 15, 16 and 17, 1892.

FIRST DAY—MORNING SESSION.

The Association met in the council chamber in the city hall, and was called to order at 9:30 A. M. by the President, Dr. J. MCFADDEN GASTON, of Atlanta, Ga.

An address of welcome was delivered by Dr. L. S. McMurtry, of Louisville, Chairman of the Committee of Arrangements, the response to which was made by the president.

The first paper read was by Dr. Bedford Brown, of Alexandria, Va., entitled,

PERSONAL RECOLLECTIONS OF THE LATE DR. BENJ. W. DUDLEY, OF LEXINGTON, KY., AND HIS SURGICAL WORK.

The speaker paid an eloquent tribute to Dr. Dudley, and characterized him as the greatest lithotomist that this country has ever produced, and the most successful in the history of the world. The speaker's close relationship to Dr. Dudley as

private pupil and assistant for two years enabled him to present a clear and faithful sketch of his character and surgical work.

EXPERIENCES IN PELVIC SURGERY.

This was the title of a paper read by Dr. A. V. L. Brokaw, of St. Louis, Mo. Of all the surgical problems difficult to solve, it may be truthfully said, that those met with in the pelvis are the most trying. The speaker knew of no surgical work which will compare with the experiencies found in the pelvis; a diversity of conditions, complications and unexpected happenings are ever presenting. In a series of many operations but few will be alike in every particular. As his experience became larger, he was free to confess his inability to correctly diagnose the character of abdominal and pelvic troubles. He had diagnosed pus tubes and found extra-uterine pregnancy; diagnosed extra-uterine pregnancy and found pus; diagnosed ovarian lesions and found the trouble located in the tubes, and *vice versa*. When well defined pelvic lesions exist, nothing short of radical measures succeed. The one condition above all others where exploratory incision should be adopted was in cases of suspected extra-uterine pregnancy. It was correct and good surgery to open the abdomen and wait for all the classical signs to appear. The symptoms of extra-uterine pregnancy were so frequently obscure and unreliable that he was firmly convinced a radical position should be taken. A case was cited in point.

DR. WILLIAM WARREN POTTER, of Buffalo, desired to indorse that portion of the paper pertaining to any early exploratory incision in cases of suspected extra-uterine pregnancy. As regards the use of the sound, he had brought an indictment against it some six or eight years ago, consequently he would not expatiate upon the subject at this time.

DR. JOSEPH TABER JOHNSON, of Washington, said that as soon as the surgeons diagnosed something in the abdominal cavity that ought not to be there, anatomically or physiologically, and was histologically wrong, it should be removed. An exploratory operation was jurisdiction in cases of suspected extra-uterine pregnancy, and the surgeon should base his further procedures upon what he finds after making the exploration.

DR. W. E. B. DAVIS, of Birmingham, Alabama, thought the pendulum relative to surgical interference had swung a little too far. He believed that a great many of the so-called "tinkerers" who succeeded in relieving their patients, did not accomplish it so much by the local treatment they used, as by having patients under their care, keeping the bowels open, giving constitutional treatment, seeing them regularly, etc. While, by so doing, they may not be cured in all cases, they were benefitted. Regarding the diagnosis, surgeons who are opening the abdomen constantly, would rarely give a positive diagnosis in the case. Dr. Davis cited the case of a woman who had an acute attack of peritonitis, and the history was the same as from pelvic abscess.

DR. BROKAW, in closing the discussion, said that in every case of suspected extra-uterine pregnancy, it was good surgery to make an exploratory incision and operate before rupture took place.

DR. CORNELIUS KOLLOCK, of Cheraw, South Carolina, read a paper on "Craniotomy Upon the Living Fœtus not Justifiable." He said this operation implied the death of the fœtus and a frightful mutilation of its body, often accompanied by serious lacerations of the vagina and adjacent tissues of the mother. Recent advances in obstetrics, gynecology and abdominal surgery contribute largely to a demonstration of the fact that a timely resort to Cæsarean section in pelvic obstruction is the great factor to success. In Germany, out of 149 cases of contracted pelvis, 109 mothers and 136 children were saved. If craniotomy had been done in those cases, 149 children would have been destroyed and probably 50 women —perhaps more, making a sacrifice of at least 199 lives. In many of these cases, exhaustion had supervened and septic influence had already been excited. This, added to a tardy disposition to union by first intention, caused by contusion of the parts involved in the uterine incision, lessened materially the woman's chances for recovery. Zweiffel was successful in twenty-nine cases out of thirty; Schauta did Cæsarean section fifteen times without a single death. Recently in eighteen operations done in Louisiana, fourteen were successful. Of eight in Ohio, six were successful. Dr. Price has

done Cæsarean section a number of times successfully. Dr. Kollock is firmly convinced that eighty-five or ninety-five per cent. of the cases of obstruction of the pelvis forbidding the delivery of the fœtus in the natural way, might be saved by a timely resort to the Cæsarean section.

DR. W. D. HAGGARD, of Nashville, emphasized the position taken by Dr. Kollock. He believes that when the profession fully realizes the immense difference in the number of lives saved by Cæsarean section over craniotomy there will be no doubt as to its preference to the latter operation.

DR. HUNTER McGUIRE, of Richmond, favored Cæsarean section. Some time ago he saw the report of a case by Dr. Thomas, of New York, where, in doing Cæsarean section, he proposed to take the uterus out of the cavity, and then open it. He thought this added very much to the danger of the operation, necessitating a larger opening, exposing the cavity of the abdomen a long time to the atmosphere, etc. He does not favor this procedure.

DR. L. S. MCMURTRY, of Louisville, said that a few years ago it would have been impossible for one to have presented the views that Dr. Kollock had without meeting with violent opposition. Cæsarean section was then regarded as an extremely heroic operation, and until recent years, the mortality therefrom was very great; but since it has been carried to the present degree of perfection by Sænger and others it has strengthened the opinions of abdominal surgeons, who now consider it preferable to craniotomy. Within the last two months symphysiotomy has been brought before the profession and practiced as an alternative in certain cases for Cæsarean section. What the future of the former operation is to be, we are not prepared to say.

DR. ARCH DIXON, of Henderson, Ky., advised Cæsarean section in a case in which he was called in consultation, but the family physician insisted upon his doing craniotomy, which was done, and while every precaution was taken with regard to rendering aseptic the field of operation, the woman developed pelvic peritonitis, and died within four days. He believed a Porro operation would have saved the life of the woman, and perhaps that of the child.

DR. W. D. HAGGARD, of Nashville, read a paper entitled:

"A Case of Extensive Hematocele Resulting from Tubal Pregnancy Rupturing into the Broad Ligament."

Although the fœtus was not found, that it was a case of tubal pregnancy with rupture into the broad ligament, is clearly established by the clinical history and post-mortem appearances summarized as follows: (1) Patient confessed having had intra-pelvic trouble previously (presumably gonorrhœa), for which she was treated locally. (2) At the time of the accident, caused by jumping from a wagon, her menses were past due. As to how long, her statements were misleading. (3) There was a fitful yet persistent flow from the uterus during her entire illness. (4) Paroxysmal, colicky pains in lower abdominal and pelvic regions of frequent occurrence. (5) Existence of a tumor above the pubes, which she probably mistook for a gravid uterus. (6) Persistent refusal to submit to a digital examination, probably fearing the detection of her pregnant state.

Post-Mortem Appearances.—(a) Enlarged and softened condition of the uterus with a patulous os, showing escape of a sero-sanguinal, stringy fluid. (b) Enlargement of the left tube with a well-defined cavity from which the fruit sac escaped. (c) Existence of a deciduous membrane, as revealed by the microscope. (d) Discoloration of the rectum, produced by blood dissecting around it, producing constriction and partial death.

DR. H. C. HOGAN, of Union Springs, Ala., reported a case of fibroid tumor of the uterus—pregnancy: rupture about the fourth month—operation, specimen. The woman, colored, was twenty-eight years of age, and from the symptoms and history of the case, he was satisfied there was a rupture, and the probabilities were that it was about the fourth month of gestation. He was also of the opinion that the rupture did not immediately destroy the fœtus, that it continued to grow in its abnormal position. The speaker felt sure that if he had operated on the case immediately after rupture, the patient's life would have been saved. In all cases of rupture he would advise Porro's operation to be done immediately; that in all cases, where the tumor is large or multiple, intra-mural or subperitoneal, with a sacciform dilatation of the posterior seg-

ment of the uterus, and, as above the pubic bone, or inaccessible, the same operation should be done. In all cases where the tumor is in front of the child, or blocking the passage, it should be done, provided the pregnancy has advanced to the full time, or there should be a hemorrhage. or rupture of the membranes, indicating that an abortion or miscarriage is imminent.

FIRST DAY—MORNING SESSION.

DR. GEO. A. BAXTER, of Chattanooga, Tenn., read a paper entitled "A New Operation for the Radical Cure of Inguinal Hernia." Dr. Baxter presented a radically different operation in principle from any yet given. It consists in a prolongation of the incision, after the ordinary management of the sac and after ligation, through the internal ring into a more or less extensive laparotomy as the exigencies of the case demand; lifting the neck of the sac into the abdominal opening above the ring and its fixation there by a deep suturing, cutting off the sac close above the peritoneum and its closure by buried suture, and a final closure of the abdominal opening by this and a more superficial set of sutures which pass across above the closed sac and peritoneum and underneath the deep fasciæ which are intended to approximate the homologous tissues of the abdominal wall. The ring is closed with crucial sutures dipping over cord and traversing the tissues, and the seminal canal closed with deep sutures alone.

Points of originality claimed: A line of incision suitable for any inguinal hernia, and by the fixation of the sac above the peritoneum, a deflection of all abdominal expulsive force from the ring and canal, and the thickened lining of the internal ring, and the method of closure of abdominal incision. Advantages claimed: Quick cure with avoidance of necessity of truss, deflection of expulsive force from internal opening and canal to abdominal parieties; advantage in being able to approach constriction either from without or within; avoidance of necessity for traction on sac or contents; ample room for treatment in diseased conditions of sac or contents, including gut operations if necessary.

(*To be continued.*)

BOOK REVIEWS.

THE DISEASES OF THE STOMACH.—By C. A. Ewald, M. D., Extraordinary Professor of Medicine at the University of Berlin; Director of the Augusta Hospital, etc. Authorized translation from the second German edition, with special additions by the author, by Morris Manges, A. M., M. D., Attending Physician to Outdoor Department Mount Sinai Hospital, New York City, etc. D. Appleton & Co., New York, 1892.

THIS work which Dr. Manges has translated from the German will prove a valuable addition to the literature now in circulation on this most important subject. It is in the shape of lectures and is, in fact, based upon the stenographic reports of remarks of Dr. Ewald at the *Feriencurse fur praktische Aerzte.* Of recent years a great deal of enthusiasm has been manifested by different investigators in this particular branch of medicine, and a work containing the accumulated results of these different men would seem altogether opportune. It will be found that in the author's references he has been very liberal towards the American profession. He states that Kinnicutt, in a paper read before the Association of American Physicians, claims to have found hydrochloric acid "almost without exception," in the stomachs of fasting suckling infants, while he himself, however, believes that normally the stomach contains only traces of hydrochloric acid and cites a noted German authority as agreeing perfectly with him in his results. In his chapter on electrization of the stomach, he refers to experiments made by Pepper and reported in an article in the *Philadelphia Medical Times*, in 1871. He also says, "it is well known that spastic strictures may appear throughout the whole length of the œsophagus, and at times may become so marked as to simulate the symptoms of hydrophobia," and cites such a case reported by Barnes, an American physician, in 1882. In the chapter on Differential Diagnosis of Cancer, he refers to the report of a case by Stoner in *Boston Medical and Surgical Journal*, in 1872, in which almost the entire stomach underwent colloid degeneration without causing any marked dis-

turbances of digestion and vomiting. In giving the etiology of gastric ulcer, he mentions the celebrated case reported by an American physician, in a paper published in Boston, 1833, entitled "Experiments and Observations on the Gastric Juice and the Physiology of Digestion," and says, "in proof of this—the transient hemorrhages and follicular suppuration due to irritating ingesta—we possess a classical witness for all time in the Canadian experimented on by Beaumont." He further speaks of a case in connection with hematemesis reported by Welch in Johns Hopkins Hospital Bulletin No. 1, of a man 50 years of age, in whom he found a ruptured miliary aneurism on a branch of the gastric artery, which gave rise to a rapidly fatal and very profuse gastric hemorrhage; and lastly, the effect of diseases of other organs upon the stomach and their reciprocal action as manifested in structural changes, as for instance, the relation between advanced atrophy of the gastric mucosa and pernicious anæmia, is mentioned by him, but adds that Henry and Osler have already called attention to this fact. It is but just to say that the translator has given to the American profession a very valuable work and one which will doubtless find a ready sale.

C. E. J.

THE PHYSICIAN'S VISITING LIST FOR 1893.—Forty-second year of its publication. Philadelphia: P. Blakiston, Son & Co. Price, $1.00.

THIS visiting list has been in use many years and the form has become almost a standard. Its publication was first begun some forty-two years ago by Lindsay & Blakiston, and has been published annually since that time. It contains leaves for the regular daily record of visits, accommodating twenty-five patients per week, and a memoranda covering the twelve calendar months, followed by those for addresses of patients and others, nurses; addresses, bills and accounts asked for, memoranda of wants, obstetric engagements, vaccination engagements, obstetric cases, record of deaths and cash account. The U. S. Pharmacopœia for 1890, which will shortly be published, adopts in a great measure the metric system of weights and measures; this will doubtless create much confusion in the minds of physicians and druggists and

lead to many misunderstandings and errors. In order to provide a guide to the proper dosage, etc., Dr. Geo. M. Gould, author of the New Medical Dictionary, has prepared a very complete table of the officinal and unofficinal drugs, with doses in both the metric and English systems; this table is published in this little book, together with a short description of the metric system, also some notes upon the metric or French decimal system of weights and measures, by Oscar Oldberg, Pharm. D., table for converting apothecary's weights and measures into grams, posological table, a list of new remedies, incompatibility, poisons and antidotes, disinfectants, examination of urine, forms of Bright's disease, diagnosis and treatment of the simpler superficial diseases of the eye, the eruptive fevers, asphyxia and apnœa, comparison of thermometers, table for calculating the period of utero-gestation and local therapeutics. C. E. J.

THE MEDICAL NEWS VISITING LIST, 1893.—Thirty patients per week. Philadelphia: Lea Brothers & Co.

WE ARE in receipt of the above little book. It is thumb-lettered and contains 104 pages for the daily visiting record, accommodating thirty names to the page, together with several pages each for clinical record, consultation practice, obstetric engagements, vaccinations, death register, addresses of patients and nurses, and cash account. The first four pages are devoted to notes upon the signs of dentition, how to find the day of confinement, thermometric scales, weights and measures, comparative scales, examination of the urine, important incompatibles, artificial respiration, table of eruptive fevers, poisons and antidotes, table of doses, therapeutic reminders and ligation of arteries. C. E. J.

THE PHYSICIANS' POCKET DAY-BOOK.—Designed by C. Henri Leonard, M. A., M. D., Detroit, Mich. Price, $1.00. Issued annually by the Illustrated Medical Journal Co., Detroit, Mich.

ACCOMMODATES daily charges for twenty-five or fifty families weekly, has complete obstetrical record for ninety-four cases and monthly memoranda for debit and credit cash account. [illegible] ains a list of doses of old and new drugs, number-

of drops in twenty minims of the chief fluid medicaments, poisons and their antidotes, tests for urinary deposits, exanthematicæ, obstetric calendar, disinfectants, weights, measures, etc. This little book is well bound and altogether well adapted to the purpose for which it is intended. C. E. J.

OVER ONE THOUSAND PRESCRIPTIONS OR FAVORITE FORMULÆ OF VARIOUS AUTHORS, TEACHERS AND PRACTICING PHYSICIANS.—Published by the Illustrated Medical Journal Co., Detroit, Mich. Price, $1.00.

THIS little volume presents the bulk of the "favorite prescriptions" that have appeared in the columns of *Leonard's Illustrated Medical Journal* from time to time during the past five years. The index has been carefully prepared, with numerous cross-references, so as to put the large number of prescriptions contained therein at the immediate service of the user of the volume. Blank pages have been inserted to allow of the copying of any particular formulæ that may commend themselves. It will be found of inestimable value.

C. E. J.

Selections and Abstracts.

THE DEADLY POLICEMAN'S CLUB AND THE BRUTAL CLUBBER.—In the October number of the *Alienist and Neurologist*, we find the following sensible editorial:

Why does modern civilization permit policemen to strike on the head with their deadly clubs? The club of the policeman is a relic of the barbarous ages and the man who would use it violently except in the plainest self-defense of imperilled life is a barbarian brute even though he may have been taught to pray to the Holy Virgin and have St. Patrick for his patron Saint. There are Christian as well as heathen brutes.

Why should a policeman strike a fellow-man with such a deadly weapon on the head? A resisting prisoner is just as easily overcome by blows on the arms and the victim's future is not thereby imperilled. The risk of insanity and death are not great from a broken arm.

The damage done by the club is not fully known to the public because its victims belong to the defenseless and friendless class, who go without sympathetic following to the public hospitals, asylums, and to Potter's field, like a poor big-headed Willie, or Hartnett, of St. Louis, now on trial in a distant city for murder done under the influence of insanity caused by a policeman's club on his head in St. Louis, several years ago while drunk.

Many of the cases of insanity attributed to drunkenness in pauper asylums are the results of policemen's club violence on the head.

Is there no regulation prohibiting striking on the head? Is there no law on the subject? If not, there should be both without delay.

Aside from the humanitarian aspect of the subject, taxpayers do not wish to have brain diseases and lunatics to be cared for at public expense, made through the brutal use of the club.

But humanity demands that the use of the club should be restricted. The club is brutal anyway. It makes both policeman and criminal brutal, and the man who would use it on an unoffending prisoner or upon an offending or offensive one, about the head, except in case of the direct necessity of defending his own life, is "a wretch whom it were base flattery to call a coward."

Science, especially psychological science, and humanity protest against the brutalism of past ages. Let the club be abolished and the clubber suppressed.

THE RELATIONS OF PELVIC DISEASE TO PHYSICAL DISTURBANCES IN WOMEN.—Dr. George H. Rohe, of Catonsville, Md., read a paper on this subject at the fifth annual meeting of the American Association of Obstetricians and Gynecologists, at St. Louis, Mo., September 20–23, 1892, pointing out the frequency with which bodily conditions influenced mental states.

In a hospital containing 200 insane women, twenty-six were found with evidence of pelvic diseases. In eighteen of these, the uterine appendages were removed with the following results:

Sixteen recovered from the operation and two died. Of the sixteen recovered, three have been discharged from the hospital completely restored, both physically and mentally. In ten, considerable improvement followed the operation in both physical and mental conditions, and in three the operation was of too recent a date to allow any definite expression of opinion.

The mental disorder present in the eighteen cases was melancholia in six cases, simple mania in one, puerperal mania in four, hysterical mania in one, periodic mania in two, hystero-epilepsy with mania in one, and epilepsy with mania in three.

The author basing his opinion upon his experience, concludes as follows:

"The facts recorded demonstrate, first, that there is a fruitful field for gynecological work among insane women; second, that this work is as practicable and can be pursued with as much success in an insane hospital as elsewhere; and third, that the results obtained not only encourage us to continue in the work, but require us, in the name of science and humanity to give to an insane woman the same chance of relief from disease of the ovaries and uterus that a sane woman has.—*Alienist and Neurologist.*

ECTOPIC PREGNANCY.

Martin, of Berlin, at the recent International Congress at Brussels, gave the results of his observation in 56 cases of ectopic gestation. So far as etiology is concerned, our knowledge scarcely extends beyond a mechanical hindrance to the passage of the ovum from the ovary to the uterus. Ovarian pregnancy has been observed, although very rarely. The most frequent location of the ovum is in the ampulla of the tube. In his case, such was the situation in 49; in 34 upon the right side, in 22 upon the left. So soon as the ovum lodges in the tube, the decidua begins an irregular development, never entirely enclosing the ovum. The serotina is less developed than in uterine pregnancy; the fœtal portion of the placenta does not differ from that of normal pregnancy. The muscular layer

of the tube does not increase progressively, but after a certain point undergoes excessive atrophy. More or less irritation of the peritoneum is present. The uninvolved portion of the tube undergoes no change except that the fimbrian extremity is closed. As the ovum increases in size, the tube becomes bent and adherent. In 11 of his cases the ovum was attached on the side of the tube next the broad ligament. The uterus increases in volume during ectopic gestation and is in a condition of general hypertrophy. The uterine decidua also develops, but to a less extent than in normal pregnancy. It often undergoes a retrograde process while the ectopic gestation continues its course. Most cases of ectopic pregnancy terminated in tubal abortion within the first three months. Martin's table shows that 15 terminated in the first month, 13 in the second, 11 in the third, 7 in the fourth, the remainder occurring before the ninth month. The fœtus attained viability but once in his cases. The interruption of ectopic pregnancy usually occurs from failure in the physiological conditions existing between the ovum and the cavity containing it. The pain which occurs at tubal abortion is caused by the passage of blood through the tube. The newly developed blood vessels burst, while the strongly developed muscular layer of the tube is not ruptured. Thus many cases result in spontaneous recovery. Convalescence, however, is prolonged, and there is danger of death from shock, hemorrhage, and the development of septic infection. Localized pelvic peritonitis is also common. Martin quotes Schauta's collection of 241 cases in which the ovum was not removed by operation. Of these, 128 ruptured into the abdominal cavity with bleeding; in 22, a hæmatocele formed with peritonitis. In 34, rupture occurred into the intestine; in 9, into the bladder; in 5, the abdominal wall was perforated. In 4, the vagina was entered; in 6, the ovum escaped through the uterus; in 4 cases it became incarcerated with ileum; add in 9 cases lithopædion was formed without especial annoyance to the patient. He had personally observed 5 cases in which rupture occurred, which were not treated by operation; all of them perished. The symptoms of ectopic gestation embrace some of those of normal pregnancy; early in the case, symptoms of peritoneal irritation predominate.

Menstruation is disordered, hemorrhage finally ensues; during the first three months, a probable diagnosis only can be made. A positive diagnosis of rupture is made by pain and collapse with profound anæmia. The child is usually not considered in the question of prognosis or operation; the prognosis for the mother, when the cases proceeded without operative interference, he found to be 68.8 per cent. mortality and 31.2 per cent. recovery. In 585 cases in which operation was performed, 76.6 per cent. recovered and 23 per cent. perished. Martin had enlarged Schauta's table and found that in 265 cases treated expectantly, 36.9 per cent. recovered, and in 515 cases operated upon, 76.7 per cent recovered. His belief is that operation is invariably indicated. The morphine treatment of Winckel is not indorsed, nor the treatment by electricity; the ovum should be completely removed; when the fœtal sac cannot be completely extirpated, it may be stitched to the abdominal wall or punctured and drained through the vagina.—*Am. Jour. of Med. Sciences.*

ULCERATIVE ENDOCARDITIS CONSECUTIVE TO GONORRHŒA.—His (*Berliner klin. Wochenschr.*, 1892, No. 40, p. 993) has reported the case of a man, nineteen years old, who, shortly after apparent recovery from an attack of gonorrhœa of but ordinary intensity, was seized with a chill, followed by an eruption of small, redish spots on various parts of the body, some of which were hemorrhagic. The heart became increased in size, and a loud, blowing systolic murmur, previously not detected, could be heard at the apex, but with greatest intensity in the course of the aorta. The temperature rose to 104.9 deg. The febrile movement was remittent. The urine was excreted in increased quantity, but contained no abnormal ingredients. At no time was there pain in the perineum or testicles. The patient grew progressively worse and died from heart failure. At the post-mortem examination hemorrhages were found beneath the skin and the various mucous and serous membranes, and in the lungs, liver, testicles, cerebellum, and medulla oblongata, while the spleen, kidneys, and lungs contained infarcts. Thrombi were present in the public plexus of veins. The heart was enlarged, the left ventricle hypertrophied. Upon the right

aortic semilunar leaflet were seated numerous excrescences, to which masses of fibrin and recent coagula were attached. Similar masses were seated upon the anterior half of the left leaflet, and a single nodule was present upon the posterior leaflet. Here and there were small areas of ulceration. The aorta presented evidences of inflammation. The other valves and orifices were normal. Microscopic examination disclosed the existence of an interstitial myocarditis, with puriform softening of a thrombus at the apex. Gonococci were looked for in the various lesions, but with doubtful results. In the tissues of the diseased aortic valve were found organisms that bore a close resemblance to gonococci.—*Am. Jour. of Med. Sciences.*

STUDY OF POST-DIPHTHERITIC PARALYSES.—Baginsky (*International Medical Magazine*) believes that the more intense the diphtheritic process in the pharynx, the earlier does paralysis follow. Paralysis of the soft palate is the most usual, and appears consecutively with albuminuria or well-delivered nephritis. The heart is often affected early, and the children die with symptoms of heart weakness.

Paralysis appearing later and with slower onset, is associated with non-gangrenous or non-septic processes. Generalization of the paralysis, or especially its localization to the diaphragm, is dangerous. Paralysis of the diaphragm is of more frequent occurrence than is generally believed. This is characterized by almost complete aphonia, cough, difficult and copious expectoration, foamy, viscid mucous, dyspnœa with thoracic respiration. The affection is usually fatal, death occurring slowly with asphyxia, bronchitis, or broncho-pneumonia, or suddenly with complete cessation of respiration.

The heart manifestations are manifold, varying from diminution in arterial tension to arlythenia, with symptoms of stasis. On auscultation, the first sound is absent, both sounds indistinct or first sound reduplicated. Accompanying this may be a rapid and extensive swelling of the liver. This is of grave prognosis. Cheyne-Stokes respiration may occur. Recovery may take place after all these symptoms have appeared.

The best results in treatment, obtained by Baginsky, have

been from the subcutaneous injection of sulphate of strychnia, 1-20 to 1-40 of a grain a day in three injections. Camphor hypodermically has also given good results.

He accepts as the pathological basis for diphtheritic paralysis, a polyneuritis, or as Virchow has expressed it, "*neuritis parenchymatosa et interstitialis proliferans.—Annuls of Gynecology and Pœdiatry.*

GONORRHŒAL INFECTION OF THE MUCOUS MEMBRANE OF THE MOUTH OF NEW-BORN INFANTS.—Rosinsky (*Zeitschrift fur Geburtshalfe und Gynakologie*, Band XXII, Heft 1 und 2), from the study of five cases of gonorrhœal infection of the mouth, in the Konigsberg obstetrical clinic, has drawn the following picture of the disease: Without preceding inflammatory redness, a white discoloration appears upon the anterior two-thirds of the tongue, the plaques of Bednar, the hamulous pterygoidews and along the ligamentum pterygomandibularum in the lower jaw, finally upon the front part of the gums. After 24 to 36 hours, the color becomes yellow. The patches elevate themselves plateau-like over the surrounding tissues, and their surfaces are raw. The superficial epithelium forms, with extravisated pus cells, a thick layer resembling the scrapings from the cut surface of a septic spleen. On the third day, the regeneration of the epithelium begins; this is marked by an inflammatory redness around the edge of the patch. Healing follows without treatment in an ideal manner, no trace of scar or discoloration remaining. From the microscopical examination of some excised tissue, Rosinsky has gleaned the following: The gonococci were never found in stained sections, intracellular. They were seldom found intracellular in the superficial flakes. Gonococci cannot penetrate into the body of healthy living ceils; they accomplish this only when the single cells are cut off from the conditions of life. In the connective tissue, gonococci invasion was found. Rosinsky believes this to be typical for pure gonorrhœal inflammation of the mucous membrane of the mouth in adults in contradistinction to infants, he believes due to the tenderness of the epithelium of the mouth in the new-born.—*Annals of Gynecology and Pœdiatry.*

THE CORSET AS A FACTOR IN PELVIC DISEASES.—(*American Gynecological Journal*, August, 1892.) By G. R. West, M. D.

This article deals at length with the injuries from what he calls the habitual use of the corset, exerting its influence on the osseous system first, the thorax second, the abdomen third and the pelvis fourth. If the author had confined himself to the abuse of the corset his paper would probably do more good. "In all probability the Indian and the Chinese and the uncorseted woman breathe with the abdominal movement of man." But it must be remembered that these various ladies are unaccustomed to the modern skirt, especially that used in England, which is heavy to begin with, and, with its trimming of braid and possibly the fashionable leather binding, is quite a burden to carry. Do away with the corset—the sensible corset, we mean—and nine times out of ten this skirt, with various other accessories, will hang fr.m the waist, and surely the pelvic contents will suffer far more than if the corset were used. We think that the corset is a natural accompaniment for the dress of modern civilization, and, until we return to the simplicity of the Greek or the Japanese, or the innocence of Eve or Pocahontas, we will have the corset always with us —*Int. Med. Mag.*

PERIODIC NOCTURNAL COUGH IN INFANTS.—(Traite des Maladies des Enfants. *Journ. de Med. et de Chir. Prat.*, 1892, lxiii, 5, p. 192; *Archives of Gynæcology*, July, 1892, p. 341.) By Baginsky.

Baginsky describes a nocturnal cough of obscure origin in infants. Without apparent cause the patient is awakened by violent cough lasting from a quarter to half an hour. At the end of the paroxysm the child again goes to sleep, and is well in the morning. Ordinarily physical examination shows nothing abnormal. Such attacks have been ascribed to malaria, but this cause can often be excluded. Most probably the condition is due to sub-acute or chronic rhino-pharyngitis or to a bronchial catarrh with hyperæsthesia of the mucous membrane of the respiratory tract, the accumulation of mucus during sleep causing irritation and thus inducing the paroxysm.—*Int. Med. Mag.*

Editorial.

PRESENT STATUS OF THORACIC SURGERY.

Those who have kept abreast of the advances in the surgical resources for chest troubles, as reported in the issues of the Annual of Universal Medical Sciences during the past three years, will fully appreciate the aggressive work in this department. But unfortunately, there are comparatively few of the members of the medical profession who have taken the trouble to ascertain the facts in regard to the various measures which have been adopted in wounds of the thorax or in the modifications of the pleural contents resulting from disease.

Notwithstanding the weight of experience in favor of hermetical sealing of penetrating wounds of the thorax, a new departure has recently been proposed by Dr. Axford, in a paper laid before the Chicago Academy of Medicine, urging a free incision and removal of the blood in traumatism of the chest. In the discussion of Axford's paper, entitled "A Plea for the Lung," the remarks of G. F. Lydston, O. L. Schmidt, J. G. Kiernan and H. N. Moyer, of Chicago, Ill., present some points of practical importance. It is a peculiar fact, says the first named gentleman, that the lung has received less attention in modern surgical procedures than other important organs. The chief step in advance, that has been taken, is the conservative one of the establishment of the principle to avoid probing in lung gun-shot wounds. If a foreign body should be located and removed, such as a bullet, the removal would be attended with more damage than the bullet would if left alone.

The older surgeons frequently bled from the arm to the point of syncope in the hope that the rest secured for the circulation would permit the formation of a clot at the site of the internal injury. This principle of rest is mostly the foundation upon which lung surgery should be based. The foreign body being left to take care of itself, the menacing in-

dications are to check hemorrhages, to secure asepsis of the wound and to promote rest.

Many of the wounds of the lung do very well if left alone. Everything depends upon whether blood vessels of any size have been cut across. The power of absorption by serous membranes is often forgotton. The serous sacs are practically huge lymph sacs and absorption from their surfaces is very active.

As Dr. Axford has suggested, it is impossible to get the pleural cavity into an aseptic condition when blood mixed air is present in considerable quantity. His suggestion of a free incision and the removal of the blood is, it seems to Lydston, logical—not as applied to every case, but to the exceptional cases, such as that upon which he has based his paper.

As the pleural cavity is already opened, he sees no objection to its free incision in suitable cases. He thinks it would be better to operate as a primary procedure for the checking of hemorrhage and the avoidance of sepsis, than to wait until a large accumulation of blood has occurred and septic decomposition has already taken place.

Schmidt points out that free incisions into the pleural cavity would convert this into an open pneumothorax, having external openings, and in all probability, also a communication with a bronchus, for only in case of a wound of the lung is this measure to be praticed. After the removal of the blood from the cavity, the favorable influence of the pressure of the blood previously in the cavity would be lost and a cessation of hemorrhage would then be due to (1) retraction of the lung tissue produced by its elasticity, producing compression of the bleeding vessel, (2) formation of a clot, due to exsanquination, (3) less mobility of the lung during respiration. Then these causes would act together; and, inasmuch as the 1st and 3rd are very indefinite in their hemostatic influence, the second cause would be the one most usually effective. But stoppage of hemorrhage by copious loss of blood is very unreliable and is a principle never used unless more certain means cannot be brought into play in the case.

Kiernan said, in dealing with the question raised by Axford, that lung surgery had received attention ere the days of anti-

septics and anæsthetics. In the Hunterian museum are the lungs of a man which had been transfixed by a jig-shaft in 1802, from which he recovered. An English sailor in 1837 was pinned to the deck of a ship by the pivot of a try-sail, which pressed through the chest, and yet he recovered. Hale of Minersville, Pa., reports a case of a 25 year old man, who had a stab wound 1 1-4 in. long in the left side, from which a portion of the lung protruded. This was excised measuring six inches long, two and one half inches in diameter at greatest width, and one inch where it was excised. The patient made a good recovery. It is the conviction of Kiernan that under antisepsis and anæsthesia the chief risks, shock and blood-poisoning, could be reduced. A patient was operated on by Fenger, ten years ago, for a gangrene cavity of the thorax who was in excellent health despite a careless mode of life.

Moyer states that one of the problems incident to the question raised by Dr. Axford is a medico-legal one. If death results from the operation on a victim of a wound, the question of how far can this be charged to the operation, might become of serious importance. Willard is of opinion that entrance of air into the pleural cavity is far more serious as regards lung collapse, when the pulmonary tissues were normal than when they were diseased. He states, and his experience is corroborated by Fenger, that incisions into tuberculous, gangrenous or suppurating pulmonary tissue can be safely undertaken. Better results are therefore to be expected in pulmonary gangrene and abscess, than from any other method of treatment.

Dr. Axford, in concluding the discussion, said he would not think of operating in all cases, only those where there was immediate danger of large hemorrhage and subsequent danger from sepsis by decomposition of blood mixed with air.—(*The Medical Standard*, February and April, 1892).

It would appear from the favorable views expressed by some of the speakers in regard to the proposition of Dr. Axford, to lay open the chest in cases of considerable hemorrhage into the pleural cavity, that this procedure met the sanction of surgeons at the present day. But on the contrary, this practice is in opposition to the best established principles which govern the treatment of penetrating wounds of the thorax; and an en-

tirely different mode of dealing with this class of cases has been adopted by those surgeons having the largest experience in thoracic wounds. It is now the recognized course of treatment to allow of the escape of all the blood which may flow out of the wound when placed in a dependent position and afterwards close the opening or openings into the pleural cavity, by suture, so as to effectually shut off the thoracic cavity from the external air. This secures the most satisfactory results.

J. McF. G.

HIGHER MEDICAL LEGISLATION.

Ye honest physicians who have so long listened with credulity to the whispers of fancy, and pursued with eagerness the phantoms of hope, can expect this legislature instead of age to perform the promise of higher medical legislation, and that the deficiences of the present day will be supplied during this session.

The bill just passed by the senate and transmitted to the house does and should have the endorsement and fullest sympathy of the medical profession of Georgia. We as a journal heartily approve it, and sincerely hope it will pass the house by the same decided vote it did the senate, and we are sure that if the different members of the legislature could look at it from the standpoint that it means protection to themselves and families, through the fact that in the future every man who expects to practice medicine in this State will not only have to attend an additional year at a medical college, but also come up before a conscientious examining board before he can qualify as a physician—a board appointed by the governor; and a particularly strong point in reference to this board is the fact that no member of the faculty of any medical college can be on the board, and that it puts the licensing power of their students to practice into other hands. Certainly all the medcal colleges of this State which have been so clamorous through the medical journals for higher medical education, should do all in their power to assist the passage of this bill.

For I am sure that there is no teacher in any school, which only requires two terms of lectures, that does not feel, if he is

at all conscientious, that these men his school graduates, would be infinitely better *qualified* to practice medicine if they could be kept three years.

The bill is in every respect a good, strong, conservative one, and will meet a long felt want—that of protecting the people from illegal and unqualified practitioners, and in the future a physician will come to you with the endorsement of his State as well as his college, and it gives the greatest pleasure to see our State arraying herself in line with the surrounding States as being in favor of higher medical legislation.

W. F. WESTMORELAND.

A NEW PROFESSORSHIP IN THE JEFFERSON MEDICAL COLLEGE.

At a meeting of the board of trustees held on Wednesday, November 30th, 1892, Dr. G. E. de Schweinitz was, on the unanimous recommendation of the faculty, elected Clinical Professor on Ophthalmology in the Jefferson Medical College.

At the time of election Dr. de Schweinitz was Professor of Ophthalmology in the Philadelphia Polyclinic and Lecturer on Medical Ophthalmoscopy in the University of Pennsylvania.

MENTHOL IN VOMTING OF PREGNANCY.—Dr. Moreiil, Wreiz- calling the work of Gottschalk, Weiss, Lahnstein, Drews, Graefe, Kaltenbach, Lomer, Jaffe, Piza, and May, concerning the use of this drug for vomiting, records its successful use in a case under his own observation, in which muriatic acid, bicarbonate of soda, ice, cherry-laurel water, morphine, bromide of soda, hyoscyamus, chloral, and cocaine had failed. The formulæ employed have been those of Gottschalk (menthol, 1; alcohol, 20; distilled water, 150; a dessertspoonful every two or three hours); of Weiss (menthol, 1; alcohol, 20; syrup, 30; which makes a better solution); of the author (10 drops of a 20 per cent. solution in olive oil, dropped in finely-powdered sugar), the last formula leaving only a sweet taste in the mouth, after a little water has been drunk. The dose of menthol for this purpose is about a grain.—*Centralblatt fur die gstammte Therapie*, 1892, Heft. 8, S. 449.

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Extract from New York Medical Journal of July 2nd, from article of Dr. Thomas S. K. Morton, read before the Philadelphia County Medical Society.

If healing of an ulceration is retarded by the presence of sloughs—and sloughs are very slow to separate in the abscence of an active suppurative process—it may be expedient to hasten their separation. If already loose at the edges, they

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may usually be dissected off without pain, by scissors and forceps. Otherwise, the best plan is to digest them out by means of pepsin or papoid. When pepsin is used for this purpose, I build a retaining wall of tough cerate about the ulcer, and then pour into the little reservoir thus obtained, enough of the following solution to cover the ulcerated area;

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